Victorian Health Incident Management System Minimum Dataset (VHIMS MDS) v2 manual 2024-25

Edition 1

VICTORIA State Government | Department of Health

To receive this publication in an accessible format >.email VHIMS2<vhims2@vahi.vic.gov.au

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

Available at VHIMS MDS website <https://vahi.vic.gov.au/ourwork/safety-and-surveillance-reporting/vhims-program-of-reforms/vhims-minimum-data-set-and-timeframes-compliance>

Contents

Section 1: Introduction

The Victorian Health Incident Management System Minimum Dataset (VHIMS MDS) is a standardised dataset that collects information about clinical and occupational health and safety (OH&S) incidents (adverse events) and near misses and hazards.

Incident data collected through the VHIMS MDS helps to drive local and statewide improvements in quality and safety. Reporting informs oversight and monitoring of the Victorian health system by the Department of Health (the department) and Safer Care Victoria (SCV) and will enable health services to compare and learn from their peers.

The VHIMS MDS must be collected in all Victorian public health services and all services under their governance structure, including community health, aged care, and bush nursing centres services, as well as in registered community health services. The term 'health services' is used in this manual to refer to in-scope organisations.

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

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

VHIMS MDS scope

Organisations required to report the VHIMS MDS include:

- 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).

Health services reporting the VHIMS MDS may be required to fulfil other reporting requirements in addition to VHIMS MDS reporting. These include but are not limited to:

- Critical Incident Response Pathway <https://www.health.vic.gov.au/incident-reporting-community-health-services>[1]
- Client Management Interface/Operational Data Store <https://www.health.vic.gov.au/research-and-reporting/reporting-requirements-and-business-rules-for-clinical-mental-health>

[1] (Department of Health, 2024)

- Sentinel Event Reporting < https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events>
- Serious Incident Response Scheme <https://www.agedcarequality.gov.au/providers/serious-incident-response-scheme>
- Statutory Duty of Candour Quarterly AIMS Reporting <https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/adverse-event-review-and-response/duty-of-candour>[2]
- Social Services Regulator notifiable incidents <https://www.vic.gov.au/ssr-reporting-notifiable-incident>[3]

Data quality statement

The VHIMS MDS and associated reporting requirements have been designed with consideration of data quality principles, including accessibility, accuracy, coherence, completeness, interpretability, relevance, timeliness, and validity.

Accessibility

The VHIMS MDS is recorded in the department's Information Asset Register.

VHIMS statewide comparison reports and early monitoring systems are currently in development and are scheduled for release in early 2025.

Accuracy

The VHIMS MDS manual is published by the department to provide clarity for all health services and information for data users on reported data elements.

Each health service should ensure they use an Incident Management System (IMS) configured to report the VHIMS MDS. Systems should be flexible and configurable to accommodate periodic changes to the VHIMS MDS.

Coherence

The department seeks to minimise the changes to the VHIMS MDS while ensuring that the collection maintains its integrity and continues to provide value. Where relevant, code sets and definitions align with other departmental data collections.

Completeness

In-scope health services are required to report the VHIMS MDS. Health services must have procedures and processes in place to ensure the necessary elements for all in-scope incidents are reported in a timely manner.

[2] (Safer Care Victoria, 2024) (Safer Care Victoria, n.d.) (Safer Care Victoria, n.d.)

[3] (State Government of Victoria, 2024)

Interpretability

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

The VHIMS MDS has replaced the VHIMS interim data collection, which operated from July 2017. While the data reported for the interim dataset and the new VHIMS MDS are different, the counts of all incidents and incidents by type from the VHIMS interim data collection are broadly comparable to the new VHIMS MDS.

Relevance

The VHIMS MDS undergoes periodic review to ensure data are relevant and continue to support the needs of stakeholders, i.e. are required by the department and SCV to fulfil their responsibilities for monitoring and oversight, and/or support meaningful comparison between health services. In addition to relevance, periodic reviews are guided by principles of collectability, applicability, utility, data quality, implementation, and consequential impact. See Changes to VHIMS MDS.

Timeliness

Health services are required to transmit all new and updated incidents to the department 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 are exempt from this requirement for 2024–25. Registered community health services may report near-real-time data at their discretion.

Validity

This manual outlines the pre-defined code sets for the VHIMS MDS and includes validations that are present when incident records are transmitted. The validations ensure that reported data only include valid codes and complies with VHIMS MDS business rules.

Communication and resources

Health service primary contact

The department communicates any VHIMS-related information/issues that require action to the health service's primary contact. This may include policy or technical-related information/issues. It is important that the primary contact can triage requests and liaise with others across the organisation to ensure information is distributed and actioned appropriately.

There is only **one primary contact** per health service. However, at the health service's discretion, this may be a shared mailbox email address. For health services in some rural health alliances, the primary contact is the rural health alliance contact as requested by these health services.

The department maintains a primary contact email contact list that will be used to communicate VHIMS-related information/issues. To change the primary contact for your health service, please use the Primary Contact Change Form <https://forms.office.com/r/8iQqBxAvv>. This form can also

be accessed via the VHIMS SharePoint site <https://dhhsvicgovau.sharepoint.com/sites/VHIMS>VHIMS SharePoint page

The VHIMS SharePoint site <ihttps://dhhsvicgovau.sharepoint.com/sites/VHIMS> is the primary source of VHIMS-related information, including program updates and resources. To register for SharePoint access, please contact VHIMS 2 email <vhims2@vahi.vic.gov.au>

Other useful links and contacts

1. **VHIMS Minimum Data Set website** <https://vahi.vic.gov.au/ourwork/vhims-program-of-reforms>This site provides information about the VHIMS MDS that is available to the public, including manuals and documents associated with the periodic change process.
2. **VHIMS CS application support** is provided by the VHIMS Support team <vhimssupport@support.vic.gov.au>.
3. **Incident Management System questions** for health services using should be directed to their vendor.
4. **VHIMS MDS related questions** should be directed to VHIMS 2 email <vhims2@vahi.vic.gov.au>

Changes to the VHIMS MDS

The department seeks to minimise the changes to the VHIMS MDS while ensuring that the collection maintains its integrity and continues to provide value.

A periodic change process commenced in 2023–24 bringing the VHIMS MDS collection in line with the department's administrative data 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 minimum data set (MDS) (compliments, complaints, and suggestions) is not yet part of the VHIMS MDS. Implementation of the feedback MDS will be considered as part of future reforms.

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

Consumer Experience, Outcomes and Safety Team

eHealth

Department of Health

VHIMS2 email address <vhims2@vahi.vic.gov.au>

History of VHIMS MDS

2024–25 VHIMS MDS v2 implemented and manual published.

Multiple changes have been made to the VHIMS MDS in version 2. Changes have focused on clinical incidents, including the review of the clinical ISR algorithm, and the addition of the clinical incident flag and APSE flag to better identify Serious Adverse Patient Safety Event (SAPSE). These changes have brought the reporting of clinical incidents in line with the reporting requirements of Safer Care Victoria.

All health services are required to commence reporting of VHIMS MDSv2 by April 2025.

2023–24 VHIMS MDS 2023–24 implemented and manual published.

Changes were made to the VHIMS MDS 2023–24 to facilitate VHIMS MDS automated API reporting.

2021–22 Publication of the VHIMS MDS Manual **Edition 1.**

2018–19 Introduction of VHIMS MDS reporting.

Section 2: Concepts and derived item definitions

Introduction

This section outlines concepts and terms related to incidents and incident management that help data users and reporters understand the VHIMS MDS data elements. The section also includes items that are derived from transmitted data.

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

Adverse patient safety event (APSE)

Classification	Concept
Definition	A clinical incident, during which treatment or care **did not** go as intended and expected.'
Guide for use	This concept is related to the *APSE flag* element. Refer to *Clinical incident and APSE flags: Guidance for health services reporting the VHIMS MDS, version 2* For further information on reporting APSE please refer to the SCV Adverse Patient Safety Event policy. APSEs that have an ISR of 1 or 2 are considered Serious adverse patient safety events (SAPSEs) and are subject to Statutory duty of candour requirements.

Age

Classification	Derived Item
Definition	Age of the affected patient client consumer or resident at the time of the incident.
Guide for use	*Age* is calculated based on the *Date of birth* and *Incident date* (for clinical records only). Age is reported in whole numbers. *Date of birth* is transmitted to the department as a data variable used in the algorithm for reporting *Age but* is not reported in the VHIMS MDS.

Campus

Classification	Concept
Definition	A physically distinct site owned or occupied by a public health service/hospital or community health service, where treatment and/or care is regularly provided to patients.
Guide for use	Victorian public health services have established campus codes used to identify campuses in other health service data collections (e.g. Agency Information

Management System (AIMS), Victorian Admitted Episode Data (VAED), Community Health Minimum Dataset (CHMDS)).

The new data element *DH Campus Code* will be reported for all incidents reported following the implementation of the VHIMS MDS version 2. All pre-existing VHIMS campuses must be mapped to existing AIMS or CHMDS campus codes. See VAED and CHMDS manuals for campus allocation rules.

VHIMS Specific rules for reporting *DH Campus Code*

1. Campus codes for acute health services campuses align with the Victorian Hospital Information Reporting System (VHIRS)/Agency Information Management System (AIMS) campus codes.
2. Registered and Integrated community health services should use the Community Health Minimum Data Set (CHMDS) Campus codes.
3. Where incidents occur off-campus, such as patient/client home or other location, the campus reported is the one where the program providing the service is based. If a single campus is not easily identifiable for example the program or staff are based across campuses, the main health service campus should be reported.
4. Aged care sites required to report the AIMS Statutory Duty of Candour (SDC) form should use the campus code used for SDC reporting.
5. Where an organisation has a service that is provided in multiple locations often not on a health service campus, for example, Pathology services, Radiation oncology, or Dialysis service, the campus code for these locations is the site that administers the service, often the main health service campus.
6. Whole of health service/organisation campus codes should be mapped to the main campus of the health service.
7. Health services that have service sites away from the hospital campus such as kitchens, corporate offices, laundries, or logistics hubs, should map these to the main health service campus code.

Health services should contact VHIMS 2 email if a new code is added to VHIRS/CHMDS and is required for VHIMS reporting.

Clinical incident

Classification	Concept
Definition	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 pose a clinical risk. For registered 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).
Guide for use	This concept is related to the *Clinical incident flag* element. Refer to *Clinical incident and APSE flags: Guidance for health services reporting the VHIMS MDS, version 2*

For further information on reporting clinical incidents please refer to the SCV Adverse Patient Safety Event policy

Harm

Classification Concept

Definition Physical or psychological damage or injury experienced by the affected person as a result of the incident.

Guide for use Harm should be assessed using a person-centred approach that considered the impact on the affected 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.

Incident Severity Rating

Classification Derived Item

Definition Incident Severity Rating (ISR) is a four-tiered rating system from 1 (most severe) to 4 (least severe) which determines the level of impact that resulted from, or could have resulted from, a reported incident. ISR is derived for clinical, OH&S (staff and visitor) and hazard incidents from responses provided for three VHIMS MDS elements.

Guide for use The Incident Severity Rating algorithm and the reported elements vary according to the Incident type.

Clinical Incidents: The ISR algorithm for clinical incidents has been reviewed for the VHIMS MDS v2 to ensure better alignment with Safer Care Victoria and Department of Health policy. The new algorithm uses three questions: *Level of harm*, *Duration of harm,* and *Level of care/treatment*. Refer to *Clinical Incident Severity Rating (ISR) Model: Guidelines for health services reporting the VHIMS MDS, version 2.*

Clinical incidents reported in previous versions of the VHIMS MDS should use the previous algorithm, which used the responses to the following three questions *Level of harm*, *Level of treatment,* and *Level of care.*

OHS (Staff) Incidents: The ISR algorithm uses responses to three questions: *Level of harm sustained*, *Required level of care,* and *Actions required*.

OHS (visitor) Incidents: The ISR algorithm uses responses to three questions: *Level of harm sustained*, *Required level of care,* and *Type of Injury*.

Hazards: The ISR algorithm for hazards uses the responses to three questions: *Level of impact*, *Level of disruption*, and *Level of intervention required*.

The ISR Algorithm is included at Section 7 Code Set List

Incident

Classification Concept

Definition An event or circumstance that resulted, or could have resulted, in unintended and/or unnecessary harm to an individual/s.

There are four incident types:

- Clinical
- OH&S (Staff)
- OH&S (Visitor)
- Hazard

Guide for use The type of incident is determined by the person affected:

Clinical Incident: An event or circumstance that resulted, or could have resulted, in unintended or unnecessary harm to a person receiving clinical care or that is a client of a service. (see also Clinical incident flag concept).

The term clinical incident encompasses client incidents (i.e. events or circumstances that occur during service delivery, resulting in harm or is reasonably likely to cause serious harm to a client**.**

- **OH&S Staff or Worker Incident:** An event resulting in harm, or which could have resulted in harm, to employees or contractors, casual staff, and volunteers. It does not include events resulting in harm to patients (clinical incidents) or visitors (OHS (Visitor) incidents)

  High consequence and serious OH&S incidents must also be reported to WorkSafe as a notifiable incident.
- **OH&S Visitor Incident:** An event resulting in harm, or which could have resulted in harm, to any person in the workplace who is not an employee, contractor, casual staff or volunteer (OHS (Staff) Incident) or a patient, consumer, client, or resident (clinical incident)
- **Hazard:** A non- event or situation where there is a recognised potential to cause harm, damage, or injury. For example, uneven tiles in a patient bathroom.

Near-miss

Classification Concept

Definition An event that did not cause harm, but that had the potential to cause harm.

Guide for use Near-miss incidents can occur for all record types, clinical, OH&S (staff and visitor) and hazard incidents. Reporting of events that had the potential to cause harm is encouraged for all organisation and reflects an organisation with a good safety culture. Health services are encouraged to identify and review circumstances where there was potential harm.

Status of incident

Classification Derived item

Definition Identifies the point at which the incident sits in the incident management journey at the latest update.

Guide for use The status of the incident provides insight into the progress of incident reporting within the health service.

- Submitted – a reporter has recorded and submitted an incident.
- Under investigation – the incident review has commenced within the health service for the incident.
- Outstanding actions – one or more review actions are still underway in the health service.
- 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'.

The table below shows the derivation used

Status ID	Status Name	Date Closed	Follow up section*	Review section**	Review Status
0	Submitted	null	null	null	
0	Submitted	null	null	not null	9
1	Under Investigation	null	not null	not null	9
1	Under Investigation	null	not null	null	
2	Outstanding Actions	null	not null	not null	7 or 8
2	Outstanding Actions	null	null	not null	7 or 8
3	Closed	not null			

***Follow up section** includes *Contributing factors, Sentinel event flag and Open disclosure.* Where any element has a value, the section is not null.

****Review section** includes *Review type* and *Review status.* Where any element has a value, the section is not null.

Section 3 Data Elements

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

Data Element Format

Specifications

Definition	A concise statement that expresses the essential nature of the data element and its differentiation from other data elements.
Label	Provides the database label for the data element for data users
Form	The format in which the data is recorded. This may include: • Boolean string • Date • GUID • Integer • List • String • Time.
Layout	The layout of characters for the data element. May include: • Free text • Reference data (standardised code set) • “Yes”/ “No” • dd numeric characters representing day of the month (Range 01–31) • mm numeric characters representing month (Range 01–12) • yyyy numeric characters representing year • System-generated code.
Size	The character limit of the field
Repeats	Indicates if repeat values are accepted
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 that relate to this data element.

Related Elements 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 Set Source Identifies the authority that developed the code set for this data item.

Data elements to be reported by record type

The table below provides a reference for the business data elements that are to be reported for each record type.

	Record type			
Data element	**Clinical**	**OH&S Staff**	**OH&S visitor**	**Hazard**
Actions required		Y		
Adverse patient safety event (APSE) flag	Y*			
Brief summary	Y	Y	Y	Y
Body part		Y*	Y*	
Client Identifier	Y			
Clinical incident flag	Y			
Contributing factors	Y*			
Date closed	Y	Y	Y	Y
Date of Birth	Y*			
Details	Y	Y	Y	Y
DH campus code	Y	Y	Y	Y
Duration of harm	Y*			
Emergency response type	Y	Y	Y	Y
Emergency response outcome	Y*	Y*	Y*	Y*
Event type	Y	Y	Y	Y
Event type sub-category	Y	Y	Y	Y
Grouping id	Y	Y	Y	Y

Health service incident identifier	Y	Y	Y	Y
If other body part specify.		Y*	Y*	
Indigenous status	Y*			
Incident date	Y	Y	Y	Y
Incident time	Y	Y	Y	Y
Incident type	Y	Y	Y	Y
Is reporter the affected staff member?		Y		
Is WorkSafe notifiable		Y		
Level of care/treatment required	Y*			
Level of disruption				Y
Level of harm clinical	Y			
Level of harm sustained		Y	Y	
Level of impact				Y
Level of intervention required				Y
Notification date	Y	Y	Y	Y
Organisation Identifier	Y	Y	Y	Y
Preventative/corrective action completion date		Y*	Y	
Preventative/corrective action id		Y	Y	
Preventative/corrective action reason not achievable.		Y*	Y	
Preventative/corrective action status		Y	Y	
Preventative/corrective action type		Y	Y	
Review id	Y	Y	Y	Y
Review status	Y	Y	Y	Y
Review type	Y	Y	Y	Y
Reporter role		Y	Y	Y
Required level of care		Y		
Sentinel event	Y*			
Sex (formerly Gender)	Y			
Specialty unit type	Y	Y	Y	Y
Type of injury		Y	Y	
Ward/location type	Y	Y	Y	Y
Was open disclosure conducted?	Y			
Where did the incident occur?		Y		
Worker role		Y*		

*Validations apply

Actions required

Specifications

Definition	The level of intervention/treatment required by the staff member affected by an OHS incident.
Label	action_required
Form	String
Layout	Reference data
Size	1-256
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	OHS (staff) records.
Reported When	Reported at the transmission of a new incident. Can be amended through the process of incident review until closure.
Code set	**24** Alternative treatment (e.g. Chiropractor) **25** Paramedic/Ambulance **26** Employee Assistance Program (EAP) **27** Physiotherapy **28** Doctor/Casualty
Reporting Guide	Reported for OH&S(staff) incidents only. *Actions* required is one of three questions used to determine the Incident Severity Rating for an OHS (staff) incidents. **Alternative treatment**: - for example, acupuncture, osteopathy, chiropractic, massage etc. **Paramedic/Ambulance** **Employee Assistance Program (EAP)**: 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. **Physiotherapy**: 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**: for example GP or emergency department care.
Validations	Reported for all new OHS (staff) records where *Level of harm sustained* is reported as 17 (Harm) and *Required level of care* is reported as 22 (Medical treatment). *Actions required* is mandatory when *Date closed* is present and where the above criteria are met.
Related Elements	*Incident type* *Level of harm sustained* *Required level of care*

Administration

Purpose	One of three questions used to determine the OH&S staff Incident Severity Rating.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019–20
Definition Source	Department of Health
Code Set Source	Department of Health

Adverse patient safety event (APSE) flag

Specifications

Definition	An identifier that an adverse patient safety event has occurred (i.e. treatment and/or care **did not** go as intended or expected).
Label	apse_flag
Form	Boolean String
Layout	“yes” / ”no”
Size	
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres
Reported For	Clinical incident records.
Reported When	Reported at any time in the process of clinical incident review.
Code set	**yes** Yes **no** No

Reporting Guide	Only reported for clinical incident records where the *Clinical Incident flag* is Yes. **Yes:** Reported where the incident is an adverse patient safety event, e.g. clinical incident has been confirmed, and treatment or care provided did not go as intended and as expected. **No:** Reported where incident is not considered an APSE. The *APSE flag* of 'No' be reported only when it is definitively clear that the event or circumstance reported does not meet the above definition. Whether a record satisfies the APSE definition may not be determined without review of the record therefore this element is not required to be reported until the record is closed. Refer to *Clinical incident and APSE flags: Guidance for health services reporting the VHIMS MDS, version 2.* See also Section 2: Adverse patient safety event
Validations	*APSE flag* is mandatory when *Date closed* is present and when the *Clinical incident flag* is reported as yes.
Related Elements	*Incident type* *Clinical incident flag* *Date closed*

Administration

Purpose	Enables distinction between APSE and non−APSE clinical incidents to support incident review, analysis, monitoring and reporting.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2024−25
Definition Source	Safer Care Victoria; Adverse Patient Safety Event (APSE) policy
Code Set Source	Department of Health

Brief summary

Specifications

Definition	Brief summary of the incident
Label	summary
Form	String
Layout	Free text

Size	200
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres
Reported For	All records
Reported When	Reported at any time in the process of incident review
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	Placeholder text for *Brief summary* is mandatory for all incidents when *Date closed* is present.
Related Elements	*N/A*

Administration

Purpose	This element is under review.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019−20

Version History

Version	Previous Name	Effective Date
1	Brief Summary	1/7/2023

Definition Source	Department of Health

Body part

Specifications

Definition	Description of body part/s injured in the incident.
Label	injured_body_part/*/body_part
Form	String
Layout	Reference data
Size	256
Repeats	Yes

Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	OHS Staff and OHS visitor records
Reported When	Reported at the transmission of a new incident. Can be amended through the process of incident review until closure.
Code set	See Body part code list (Section 7: Code set list)
Reporting Guide	Report this item when *Type of injury* has been reported as any item except “Emotional/Psychological”
Validations	*Body part is required where Type of injury* does not equal “Emotional/Psychological” *Body part* is mandatory when *Date closed* is present and the above criteria are met.
Related Elements	*Incident type* *Type of Injury*

Administration

Purpose	Enables analysis of OH&S staff and visitor incidents.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019-20
Definition Source	Department of Health
Code Set Source	Department of Health

Client identifier

Specifications

Definition	The unique identifier related to the patient, client, resident, or consumer generally sourced from the health service patient administration system
Label	client_identifer
Form	String
Layout	Free text
Size	1-200
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.

Reported For	Clinical incident records.
Reported When	Reported at the transmission of a new incident
Code set	N/A
Reporting Guide	Report the unique identifier for the affected patient, consumer, client, or resident.
Validations	N/A
Related Elements	*Incident type*

Administration

Purpose	Enables linkage to Department of Health administrative data sets
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019-20
Definition Source	Department of Health
Code Set Source	Department of Health

Clinical incident flag

Specifications

Definition	An identifier that indicates the incident reported is confirmed as a clinical incident, (i.e. unintended or unnecessary harm has occurred while the affected person was receiving clinical care).
Label	is_this_a_clinical_incident
Form	Boolean string
Layout	‘yes”/”no”
Size	N/A
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	Clinical incident records.
Reported When	Reported at any time in the process of clinical incident review.
Code set	**yes** -Yes **no** - No
Reporting Guide	**Yes:** Reported where the record is confirmed to be a clinical incident, i.e. unintended or unnecessary harm has occurred while the affected person was receiving clinical care, or during the provision of a non-clinical service.

No: Reported where the record is not a clinical incident.

The *clinical incident flag* of 'No' should be reported only when it is definitively clear that the event or circumstance reported does not meet the above definition.

Whether a record satisfies the clinical incident definition may not be determined without review of the record therefore this element is not required to be reported until the record is closed.

Refer to *Clinical incident and APSE flags: Guidance for health services reporting the VHIMS MDS, version 2.*

Validations

Clinical incident flag is mandatory for clinical incidents when *Date closed* is present.

Related Elements

Incident type

Adverse patient safety event (APSE) flag

Date closed

Administration

Purpose

Enables identification of non-incident clinical records, enabling these to be excluded from MDS reporting.

Principal Data Users

Safer Care Victoria and Department of Health

Collection Start

2019−20

Version History

Version	Previous Name	Effective Date
1	Is this related to care in this organisation?	2024−25

Definition Source

Safer Care Victoria

Code Set Source

Department of Health

Date closed

Specifications

Definition

The date the incident is signed-off and closed.

Label

signoff_close_date

Form

Date

Layout

yyyy-mm-dd

Size

256

Repeats

N/A

Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	All records
Reported When	Reported when an incident has been closed.
Code set	N/A
Reporting Guide	Reported when the organisation considers that they have finalised the review of an incident. All VHIMS MDS data elements are required to transmit an incident when a Date Closed is recorded.
Validations	*Date closed* must be greater or equal to *Incident date and Notification date*.
Related Elements	*Incident date* *Notification date.*

Administration

Purpose	Enables analysis incident management processes, potentially identifying areas with incomplete, or barriers to investigations.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019-20
Definition Source	Department of Health
Code Set Source	Department of Health

Contributing factors

Specifications

Definition	A circumstance, an action or other factor identified through incident review and analysis, as having contributed to, or increased the risk of, the incident.
Label	contributing_factors
Form	String
Layout	Reference data
Size	256
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	For all clinical records with an ISR of 1 or 2.

Reported When	Reported at any time in the process of incident review.
Code set	See *Contributing factors* code list (Section 7: Code set list)
Reporting Guide	Select from the list of contributing factors. Multiple contributing factors can be reported per record.
Validations	*Contributing factors* are mandatory for all incidents where ISR is 1 or 2 and *Date closed* is present.
Related Elements	*Incident type* *ISR (derived)* *Date closed*

Administration

Purpose	Enables identification of factors that contributed to the incident to support incident review, analysis, monitoring and reporting.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019-20
Definition Source	Department of Health
Code Set Source	Department of Health

Date of birth

Specifications

Definition	The date of birth of the affected patient, client, consumer, or resident.
Label	date_of_birth
Form	Date
Layout	yyyy-mm-dd
Size	256
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	Clinical records.
Reported When	Reported at the transmission of a new incident.
Code set	N/A
Reporting Guide	Used to derive the age of the affected patient, client, consumer, or resident at the time of the incident. The derivation uses *Date of birth* and *Incident date*.

Validations	*Date of birth* is mandatory for all clinical incidents where *Client identifier* is reported and *Date closed* is present.
Related Elements	*Incident type* *Incident date* *Age (derived)*

Administration

Purpose	Enables the derivation of *Age* which is used for demographic analysis and trend analysis of reported incidents.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019–20
Definition Source	Department of Health
Code Set Source	Department of Health

Details

Specifications

Definition	Details of the incident
Label	details
Form	String
Layout	Free text
Size	5000
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres
Reported For	All records
Reported When	Reported at any time in the process of incident review.
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	Placeholder text for *Details* is mandatory for all incidents when *Date closed* is present.
Related Elements	*N/A*

Administration

Purpose	This element is under review.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019−20

Version History

Version	Previous Name	Effective Date
1	Details	1/7/2023

Definition Source	Department of Health

DH campus code

Specifications

Definition	The health service campus where the incident occurred, or the health service campus responsible for the program or service providing the care related to the incident.
Label	dh_campus_code
Form	String
Layout	Reference data
Size	256
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	All records.
Reported When	Reported at the transmission of a new incident.
Code set	DH campus code list (see Section 7 Code Set List)
Reporting Guide	Incidents created in VHIMS MDS v2 must report a campus code from the DH campus code list. See Section 2: Campus.
Validations	*DH campus code* is dependent on *Organisation*. *DH campus code* is mandatory for all incidents at first transmission.
Related Elements	*Organisation*

Administration

Purpose	Enables identification of the responsible health service campus for review, analysis, monitoring and reporting. Allows for comparison of VHIMS MDS data with activity data
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2024−25
Definition Source	Department of Health
Code Set Source	Department of Health

Duration of harm

Specifications

Definition	An indication of the expected duration of harm that has resulted from the reported incident.
Label	duration_of_harm
Form	String
Layout	Reference data
Size	256
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	Clinical incidents records.
Reported When	Reported at the transmission of a new incident. Can be amended through the process of incident review until closure.
Code set	**56 -** Permanent **57 -** Temporary
Reporting Guide	Only reported for clinical incident records when *Level of Harm* is reported as **Severe or Moderate.** Duration of harm is defined as follows: **56 - Permanent** The harm the individual experienced is, or is most likely to be, permanent. **57 - Temporary** The harm the individual experienced is, or is most likely to be, temporary.

	For comprehensive guidance on reporting Clinical ISR elements, refer to *Clinical Incident Severity Rating (ISR): Guidance for health services reporting the VHIMS MDS, version 2*
Validations	*Duration of harm* is mandatory for clinical incidents when *Date close* is present and *Level of harm clinical* is severe or moderate.
Related Elements	*Incident type* *Level of harm clinical* *Level of care/treatment required.* *Date closed*

Administration

Purpose	This is one of three questions used to determine the Incident Severity Rating (ISR) for clinical incidents. See ISR in Section 2.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2024–25
Definition Source	Department of Health
Code Set Source	Department of Health

Emergency response type

Specifications

Definition	The type of emergency response called or activated as a result of an incident.
Label	emergency_response_type
Form	Integer
Layout	Reference data
Size	
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	All incident types.
Reported When	Reported at any time in the process of incident review.
Code set	**1** Code Black (serious threat and/or involving a weapon) **2** Code Brown (external disaster) **3** Code Grey (unplanned) **4** Code Orange (evacuation) **5** Code Purple (bomb threat)

	6 Code Red (fire/smoke) **7** Code Yellow (internal emergency) **8** MET/Code Blue (rapid response) **9** Obstetric Emergency **10** No Emergency Response Required **11** Code Grey (planned)
Reporting Guide	Report the appropriate code that is called or activated for the emergency related to the reported incident. Where no emergency code is called report No Emergency Response Required. The list of Emergency response types aligns with Australian Standard 4083. If health services have additional codes, they should work with their vendor to map these additional codes to the most appropriate code in the VHIMS MDS list **Code Grey (Unplanned)** (previously called Code Grey (unarmed threat) - is an emergency response initiated by staff for immediate assistance with a current incident. **Code Grey (Planned)** - is initiated by staff for anticipated assistance with a scheduled event (such as a patient appointment), where following a risk-based assessment, it is anticipated that an incident may occur
Validations	Element is mandatory for all incident types when *Date closed* is reported.
Related Elements	*Emergency response outcome* *Date closed*

Administration

Purpose	To provide important information to Department of Health for monitoring the quality and safety of patient, client resident, staff and visitors to Victoria's health services particularly monitoring of aggression and violence in health services code-grey-standards-sep-2017-pdf.pdf (health.vic.gov.au).		
Principal Data Users	Safer Care Victoria and Department of Health		
Collection Start	2019−20		
Version History	Version	Previous Name	Effective Date
	1	If Yes, Type of Emergency Response	2024−25
Definition Source	VAHI		
Code Set Source	VAHI		

Emergency response outcome

Specifications

Definition	The outcome of a planned or unplanned code grey
Label	outcome_response_code_grey
Form	String
Layout	Reference data
Size	256
Repeats	No
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	All incident types.
Reported When	Reported for all incidents where E*mergency response type equals* 'Gode Grey (planned)' or 'Code Grey (unplanned)'.
Code set	**1** No violence or aggression occurred. **2** Situation resolved prior to code grey arrival. **3** Clinically led Code Grey response implemented. **4** Security only response
Reporting Guide	This field has been introduced to align with the departments Code Grey Standards (2017) <https://www.health.vic.gov.au/worker-health-wellbeing/code-grey-and-code-black> To be reported whenever code grey is reported at type of emergency response
Validations	*Emergency response outcome* is mandatory for all incident types when *Date closed* is present and *Emergency response type* is reported as 3 - Code Grey (unplanned) or 11 -Code Grey (planned).
Related Elements	*Emergency response type* *Date closed*

Administration

Purpose	To provide important information to Department of Health for monitoring the quality and safety of patient, client resident, staff and visitors to Victoria's health services particularly monitoring of aggression and violence in health services Code Grey Standards (2017) <https://www.health.vic.gov.au/worker-health-wellbeing/code-grey-and-code-black>
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2024−25
Definition Source	DH; Departments Code Grey Standards.

Code Set Source	DH; Departments Code Grey Standards.

Event type

Specifications

Definition	A descriptor classifying the cause of harm that occurred, or could have occurred, as a result of the incident.
Label	event_types
Form	list
Layout	Reference data (list of event code with pipe delimiters)
Size	256
Repeats	Yes
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	All records.
Reported When	Reported at the transmission of a new incident.
Code set	See Section 7 Code list for full code set for clinical, OH&S, and hazard event types.
Reporting Guide	The *event type* classification determines the additional information (known as *event type subcategories*) required to further describe the cause of the incident (i.e. process/type, problem, and related questions). The event type taxonomy is unique to incident type, i.e. clinical incident event type taxonomy cannot be used to classify an OH&S incident.
Validations	Multiple *event types* are allowable for each incident. At least one *Event type* is mandatory for all incidents at first transmission. *Event type* is dependent on *Incident type.*
Related Elements	*Incident type* *Event type sub-categories* (type problem, process and related questions)

Administration

Purpose	Enables classification of incidents into categories, for review, analysis, monitoring and reporting.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019−20

Definition Source	Department of Health
Code Set Source	Department of Health

Event type sub-category

Specifications

Definition	*Sub-categories* for the *Event Type* reported capturing further details related to the types, processes or problems of the reported incident.
Label	various
Form	String
Layout	Reference data and Free text
Size	256
Repeats	Yes
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	All records.
Reported When	Reported at the transmission of a new incident.
Code set	See Section 7 Code list for full code set for clinical, OH&S, and hazard /event types and subcategories.
Reporting Guide	Following the selection of an *Event Type* additional information required to further describe the cause of the incident (i.e. process/type, problem, and related questions) will be required to be completed The event type taxonomy is unique to incident type, i.e. clinical incident event type taxonomy cannot be used to classify an OH&S incident.
Validations	Event type subcategories are determined by incident type and event type. At least one *Event type* is mandatory for all incidents at first transmission including the related *Event type subcategories*
Related Elements	*Incident type* *Event type*

Administration

Purpose	Enables classification of incidents into categories, for review, analysis, monitoring and reporting.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019−20

Definition Source	Department of Health
Code Set Source	Department of Health

Health service incident identifier

Specifications

Definition	An identifier (number or code) unique to each incident within an organisation. The identifier is generated by the health service incident management software and is used to identify an incident record.
Label	hs_incident_id
Form	String
Layout	System generated code
Size	256
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres reporting via the VHIMS API.
Reported For	All records.
Reported When	Reported at the transmission of a new incident.
Code set	Organisation generated. Individual sites may use their own alphabetic, numeric or alphanumeric coding system.
Reporting Guide	This code should be unique within the organisation for each incident. Health services that change vendors must ensure that their new software does not duplicate values sent from their previous system. It is permissible to use upper case or lower-case alpha characters, digits 0 to 9, dashes, spaces or apostrophes. Identifiers are not case-sensitive.
Validations	*Health service incident ID* is mandatory for all incidents at first transmission (API only).
Related Elements	*Organisation*

Administration

Purpose	Enables reconciliation of reported incidents between the department and health service systems.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2024−25
Definition Source	Department of Health

Code Set Source	System generated (health service software).

If other body part, specify

Specifications

Definition	Description of body part/s injured when 'other' is reported for Body *part*.
Label	injured_body_part/*/other
Form	String
Layout	Free text
Size	200
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	Reported for OHS Staff and OHS visitor records
Reported When	Reported at the transmission of a new incident. Can be amended through the process of incident review until closure.
Code set	Free text.
Reporting Guide	Include a description of the affected *Body part* if it is not available in the list and *Other* has been reported.
Validations	Only reported for OHS incidents where Other has been selected at *Body Part.* *If other body part, specify* is mandatory when *Date closed* is present and the above criteria are met.
Related Elements	*Incident type* *Type of Injury* *Body part.*

Administration

Purpose	Enables the analysis of type and anatomical location of injury.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019-20
Definition Source	Department of Health
Code Set Source	Department of Health

Indigenous status

Specifications

Definition	Identifier that the affected person identifies as Aboriginal and/or Torres Strait Islander.
Label	indigenous_status
Form	String
Layout	Reference data
Size	256
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	Clinical incident records.
Reported When	Reported at transmission of new incident.
Code set	**1** Aboriginal but not Torres Strait Islander origin **2** Torres Strait Islander but not Aboriginal origin **3** Both Aboriginal and Torres Strait Islander origin **4** Neither Aboriginal or Torres Strait Islander origin **8** Question unable to be asked. **9** Patient refused to answer.
Reporting Guide	**Code 8 Question unable to be asked** should only be used under the following circumstances: • When the patient's medical condition prevents the question of Indigenous Status being asked; or • In the case of an unaccompanied child who is too young to be asked their Indigenous Status. **Collect for every clinical incident.** This information must be collected for every clinical incident. Systems must not be set up to input a default code
Validations	*Indigenous status* is mandatory for all clinical incidents where *Client identifier* is reported and *Date closed* is present.
Related Elements	*Client identifier* *Incident type* *Date closed*

Administration

Purpose	Enables demographic analysis and trend analysis of reported incidents.
Principal Data Users	Safer Care Victoria and Department of Health

Collection Start	2024−25
Definition Source	National Health Data Dictionary
Code Set Source	NHDD (DH modified)

Incident date

Specifications

Definition	The date on which the incident occurred.
Label	incident_date
Form	Date
Layout	yyyy-mm-dd
Size	256
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	All records
Reported When	Reported at the transmission of a new incident.
Code set	N/A
Reporting Guide	The reported date should be the date that the incident occurred. It can be prior to the current date for incidents that are being reported retrospectively. Incidents that are recorded as having occurred in the past are accepted however health services must ensure that all incident dates that are earlier than the commencement of the VHIMS2 MDS (1 July 2017) are reviewed to ensure that that a historical date is accurate. Mistakes, for example, a date of birth entered as an incident date field, should be identified and corrected.
Validations	A valid date must be entered. *Incident date* cannot be in the future and must not be greater than the *Notification date.* *Incident date* is mandatory for all incidents at first transmission.
Related Elements	*Notification date*

Administration

Purpose	Enables time series reporting and supports analysis of when incidents are occurring.
Principal Data Users	Safer Care Victoria and Department of Health

Collection Start	2019−20
Definition Source	Department of Health
Code Set Source	N/A

Incident time

Specifications

Definition	The time at which the incident occurred.
Label	incident_time
Form	Time
Layout	hh:mm tt
Size	256
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	All records
Reported When	Reported at the transmission of a new incident.
Code set	N/A
Reporting Guide	Report the time that the incident occurred. Estimates of *Incident time* are acceptable where the actual time is not known.
Validations	A valid time must be entered. *Incident time* is mandatory for all incidents at first transmission.
Related Elements	*N/A*

Administration

Purpose	Enables time series reporting and supports analysis of when incidents are occurring.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019−20
Definition Source	Department of Health
Code Set Source	N/A

Incident type

Specifications

Definition	A classification of the incident based on who was harmed, or could have been harmed, by the incident.
Label	incident_type
Form	String
Layout	Reference data
Size	N/A
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	All records.
Reported When	Reported at the transmission of a new incident.
Code set	**clinical** Clinical record type **ohs-staff** OH&S (staff) record type **ohs-visitor** OH&S(visitor) record type **hazard** Hazard record type
Reporting Guide	**clinical – Clinical Incidents-** records where the individual who would be harmed or potentially harmed is a patient, client, resident, or consumer. **ohs-staff – Occupational Health and Safety – Staff Incidents**- records where the individual harmed or potentially harmed is an employee, contractor, or volunteer of the organisation. **ohs-visitor – Occupational Health and Safety – Visitor Incidents** - records where the individual harmed or potentially harmed was a visitor to the health service or a member of the public in a community setting. **hazard – Hazard Incidents –** records where no identifiable individual was harmed but where an individual or group of individuals could have been harmed as a result of the situation.
Validations	See *Section* 2: Incident *Incident type* is mandatory for all incidents at first transmission.
Related Elements	Multiple elements - *Incident type* is important in determining the elements that need to be reported.

Administration

Purpose	Enables identification of the type of incident for review, analysis, monitoring and reporting.		
Principal Data Users	Safer Care Victoria and Department of Health		
Collection Start	2019−20		
Version History	Version	Previous Name	Effective Date
	1	Notification Type	2024−25
Definition Source	Department of Health		
Code Set Source	Department of Health		

Is reporter the affected staff member?

Specifications

Definition	A flag used in OHS Staff reports to indicate if the reporter of the incident is the affected staff member.
Label	Is_reporter_the_affected_staff_member
Form	Boolean string
Layout	“yes” / ”no”
Size	N/A
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	All OHS Staff records.
Reported When	Reported at the transmission of a new incident.
Code set	**yes** Yes **no** No
Reporting Guide	**Yes** - reported where the person reporting the incident is also the affected staff member **No** - reported where the person reporting the incident is not the affected staff member.
Validations	*Is reporter the affected staff member* is mandatory for all OHS (staff) incidents when *Date closed* is present.
Related Elements	*Incident type* *Reporter role* *Worker role*

Administration

Purpose	Enables identification of impacted patient/workforce population for review, analysis, monitoring and reporting.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019–20
Definition Source	Department of Health
Code Set Source	Department of Health

Is WorkSafe notifiable

Specifications

Definition	Flag to indicate if the incident should be notified to WorkSafe.
Label	is_worksafe_notifiable
Form	Boolean string
Layout	“yes”/ “no”
Size	N/A
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	All OHS Staff records.
Reported When	Reported when it is decided that an incident meets the criteria of being WorkSafe notifiable
Code set	**yes** -Yes **no** - No
Reporting Guide	Health services should follow the WorkSafe notifiable incident criteria guidelines to determine if reportable. **Yes** The incident meets the criteria of a WorkSafe notifiable incident **No** The incident does not meet the criteria of a WorkSafe notifiable incident Note: Department of Health does not notify WorkSafe. Health services are responsible for meeting their WorkSafe notification obligations.

Validations	*Is WorkSafe notifiable?* Is mandatory for all OHS (staff) incidents when *Date closed* is present.
Related Elements	*Incident type*

Administration

Purpose	Enables identification of impacted workforce population for review, analysis, monitoring and reporting.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019–20
Definition Source	Department of Health
Code Set Source	Department of Health

Level of disruption

Specifications

Definition	The level disruption that results from a hazard incident.
Label	level_of_disruption
Form	Integer
Layout	Reference data
Size	N/A
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	Hazard records.
Reported When	Reported at the transmission of a new incident. Can be amended throughout the process of incident review until closure.
Code set	**34** No or minimal disruption <1 hour **35** Minor disruption <24 hours **36** Moderate disruption >24 hours **37** Major shutdown unit or site
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	*Level of disruption* is mandatory for all new hazard incidents when *Date closed* is present.
Related Elements	*Incident type* *Level of impact* *Level of intervention*

Administration

Purpose	This is one of three questions used to determine the Incident Severity Rating (ISR) for hazard incidents. See ISR in Section 2.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2024−25
Definition Source	Department of Health
Code Set Source	Department of Health

Level of harm clinical

Specifications

Definition	The severity of harm that the affected person experienced.
Label	level_of_harm
Form	String
Layout	Reference data
Size	256
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	Clinical incident records.
Reported When	Reported at the transmission of a new incident. Can be amended throughout the process of incident review until closure.

Code set	**50** – Death **51** - Serious Sexual Safety Event **52** - Severe **53** - Moderate **54** - Minor **55** - No Harm
Reporting Guide	Only reported for clinical incident records. For comprehensive guidance on reporting Clinical ISR elements, refer to *Clinical Incident Severity Rating (ISR): Guidance for health services reporting the VHIMS MDS, version 2*
Validations	*Level of harm clinical* is mandatory for all clinical incidents when *Date closed* is present.
Related Elements	*Incident type* *Duration of harm* *Level of treatment/care required.* *Date closed*

Administration

Purpose	This is one of three questions used to determine the Incident Severity Rating (ISR) for clinical incidents. See ISR in Section 2.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2024−25
Definition Source	Department of Health
Code Set Source	Department of Health

Level of harm sustained

Specifications

Definition	The harm sustained by the worker or visitor affected by the reported OH&S incident.
Label	level_of_harm_sustained
Form	String
Layout	Reference data
Size	256
Repeats	N/A

Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	All OHS (staff) and OHS (visitor) records.
Reported When	Reported at the transmission of a new incident. Can be amended throughout the process of incident review until closure.
Code set	**16** No harm **17** Harm **18** Death
Reporting Guide	One of three questions used to determine the Incident Severity Rating for an OHS (staff) or OHS (visitor) incident. **No harm** - There was no harm to the affected staff member, volunteer or visitor as the incident did not reach them, or it did, but did not impact their usual level of health and function. **Harm** - One or more systems or components of the affected staff member, volunteer or visitor'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 affected staff member, volunteer or visitor died at the time or following the incident.
Validations	*Level of harm sustained* is mandatory for all OH&S incidents when *Date closed* is present.
Related Elements	*Incident type* *Required level of care* *Actions required (OHS (staff))* *Treatment required (OHS (visitor))*

Administration

Purpose	One of three questions used to determine the staff and visitor OH&S Incident Severity Rating. See ISR in Section 2
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019–20
Definition Source	Department of Health
Code Set Source	Department of Health

Level of impact

Specifications

Definition	The level impact that results from a hazard incident.
Label	level_of_impact
Form	Integer
Layout	Reference data
Size	N/A
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	Hazard records.
Reported When	Reported at the transmission of a new incident. Can be amended throughout the process of incident review until closure.

Code set

29	No impact - Could have happened
30	No impact - Did happen
31	Minor impact - Local area
32	Moderate impact - Local campus
33	Major impact - More than one campus/organisation wide

Reporting Guide

Level of impact is reported for all hazard records and 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	*Level of disruption* is mandatory for all hazard incidents when *Date closed* is present.
Related Elements	*Incident type* *Level of Disruption* *Level of intervention*

Administration

Purpose	One of three questions used to determine hazard Incident Severity Rating. See ISR in Section 2
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019–20
Definition Source	Department of Health
Code Set Source	Department of Health

Level of intervention required

Specifications

Definition	The level intervention that was required as a result of a hazard incident
Label	level_of_intervention_required
Form	Integer
Layout	Reference data
Size	N/A
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	Hazard records.
Reported When	Reported at the transmission of a new incident. Can be amended throughout the process of incident review until closure.
Code set	**38** No intervention required **39** Minor - Local area intervention required to resolve issue

40	Moderate - Local division intervention required to resolve the incident
41	Major - Group wide intervention required to resolve issue

Reporting Guide	Report the most appropriate level of intervention required as a result of the incident
Validations	*Level of disruption* is mandatory for all hazard incidents when *Date closed* is present.
Related Elements	*Incident type* *Level of Disruption* *Level of impact*

Administration

Purpose	One of three questions used to determine hazard Incident Severity Rating. See ISR in Section 2
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019–20
Definition Source	Department of Health
Code Set Source	Department of Health

Level of treatment/care required

Specifications

Definition	Indication of the level of treatment or care provided to the patient as a result of the incident, generally this will be care/treatment that would not have been required if the incident had not occurred.
Form	String
Layout	Code
Size	256
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	Clinical incident records
Reported When	Reported at the transmission of a new incident, where *Duration of harm* is reported as ‘Temporary.’ Can be amended through the process of incident review until closure.

Code set	**58** - Advanced **59** - Intermediate **60** - Minor **61** – No additional treatment/care
Reporting Guide	Only reported for clinical incident records, where *Level of harm clinical* is severe or moderate, and *Duration of harm* is temporary. Level of treatment/care is defined as follows: **58 - Advanced** Life-saving care or treatment, intensive care unit, major surgical or medical intervention, high dependency psychiatric care, long term care or other high acuity specialist care, or a change to the individual's goals of care, that would not have otherwise been required if the incident had not occurred. **59 - Intermediate** Surgical or medical intervention, psychiatric or psychological care, extended medium term care, therapeutic intervention, invasive diagnostics, increased length of stay greater than 72 hrs, referral to additional care team/s (including emergency department) for treatment exceeding assessment or single occasion treatment, or an increase in acuity of hospital care beyond increased monitoring and observations that would not have otherwise been required if the incident had not occurred**.** **60 Minor** First aid, minor therapeutic interventions, increased monitoring or observations, minor or one occasion counselling or psychological support, non-invasive diagnostics, or referral to additional care team/s (including emergency department) for assessment or single occasion treatment that would not have otherwise been required if the incident had not occurred. **61 - None** No additional treatment or care was required besides an initial review to establish if the individual was harmed. For comprehensive guidance on reporting Clinical ISR elements, refer to *Clinical Incident Severity Rating (ISR): Guidance for health services reporting the VHIMS MDS, version 2*
Validations	*Level of treatment/care* is mandatory for all clinical incidents when *Date closed* is present and 'Temporary' is reported for *Duration of harm.*
Related Elements	*Incident type* *Level of harm clinical* *Duration of harm*

Administration

Purpose	This is one of three questions used to determine the Incident Severity Rating for clinical incidents. See ISR in Section 2

Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2024–25
Definition Source	Department of Health
Code Set Source	Department of Health

Notification date

Specifications

Definition	Date on which the health service was notified of the incident. This date is generally the date the incident was recorded in the incident management system.
Label	notification_date
Form	Date
Layout	yyyy-mm-dd
Size	256
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	All Incident types
Reported When	Reported at the transmission of a new incident.
Code set	N/A
Reporting Guide	This element is the date that the incident was reported in the incident management system.
Validations	*Notification date* should be greater than or equal to *Incident date* and less than or equal to *Date closed*. *Notification date* is mandatory for all incidents at first transmission.
Related Elements	*Date closed* *Incident date*

Administration

Purpose	This element will be used for VHIMS MDS reporting. Incident data will not be included in benchmarking reports until 30 days following the notification date, to allow sufficient time for health services to review incidents.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019−20

Definition Source	VAHI
Code Set Source	VAHI

Organisation identifier

Specifications

Definition	Unique organisation ID number of the organisation that is submitting the incident report.
Label	organisation_identifier
Form	Integer
Layout	Reference data
Size	N/A
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	All incident records.
Reported When	Reported at the transmission of a new incident.
Code set	Code provided by Department of Health
Reporting Guide	The organisation ID field is reported for each reported incident. The organisation ID is provided on request from Department of Health and is unique to each organisation for each Incident Management System they use to report VHIMS MDS. Health services wishing to change vendor are required to work with the new vendor and the department to ensure that a new organisation identifier is provided.
Validations	*Organisation identifier* must be valid. *Organisation identifier* is mandatory for all incidents at first transmission.
Related Elements	*DH Campus code.*

Administration

Purpose	Enables identification of the organisation reporting the incident and supports analysis of incidents
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019−20
Definition Source	Department of Health

Code Set Source	Department of Health

Preventative/corrective action completion date

Specifications

Definition	The date on which preventative or corrective actions were completed
Label	preventative_corrective_actions/*/completion_date
Form	Date
Layout	yyyy-MM-dd
Size	N/A
Repeats	Yes
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	Reported for OHS Staff and OHS visitor records
Reported When	Reported at any time in the process of incident review.
Code set	N/A
Reporting Guide	The date the preventative or corrective action was completed should be recorded for each action.
Validations	*Preventative/corrective action completion date* must be greater than or equal to *Incident date.* *Preventative/corrective action completion data* is mandatory if *Preventative corrective action status* is reported as '11' and *Date closed* is present.
Related Elements	*Date closed* *Incident type* *Preventative/corrective action id* *Preventative/corrective action status* *Preventative/corrective action type*

Administration

Purpose	Enables monitoring of trends in review and management of incidents.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019-20
Definition Source	Department of Health

Code Set Source	Department of Health

Preventative/corrective action reason not achievable.

Specifications

Definition	Description of reason the preventative/correction action was not achievable.
Label	preventative_corrective_actions/*/why_not_achievable
Form	String
Layout	Free text
Size	5000
Repeats	Yes
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	Reported for OHS Staff and OHS visitor records
Reported When	Reported at any time in the process of incident review.
Code set	N/A
Reporting Guide	A reason why a preventative/corrective action has not been achieved is only required to be reported when *Status of preventative/corrective action* is reported as *12 – Not achievable.*
Validations	*Preventative/corrective action reason not achievable* is mandatory if *Preventative corrective action status is* reported as '12' and *Date closed* is present.
Related Elements	*Date closed* *Incident type* *Preventative/corrective action id* *Preventative/corrective action type* *Preventative/corrective action status*

Administration

Purpose	Enables monitoring of trends in review and management of incidents.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019-20
Definition Source	Department of Health
Code Set Source	Department of Health

Preventative/corrective action status

Specifications

Definition	Description of the status of any reported preventative and corrective actions that are associated with an incident
Label	preventative_corrective_actions/*/status
Form	String
Layout	Reference data
Size	N/A
Repeats	Yes
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	Reported for OHS Staff and OHS visitor records
Reported When	Reported at any time in the process of incident review
Code set	**10** - Not implemented **11** - Implemented **12** - Not achievable
Reporting Guide	Select to appropriate code/s representing the status of each preventative or corrective action that has been reported
Validations	*Preventative/corrective action status* is mandatory for OHS incidents when *Preventative/corrective action type* is not null.
Related Elements	*Date closed* *Incident type* *Preventative/corrective action completion date* *Preventative/corrective action id* *Preventative/corrective action reason not achievable* *Preventative/corrective action type*

Administration

Purpose	Enables monitoring of trends in review and management of incidents.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019-20
Definition Source	Department of Health
Code Set Source	Department of Health

Preventative/corrective action type

Specifications

Definition	Description of the action or potential action to eliminate the cause of the incident
Label	preventative_corrective_actions/*/type
Form	String
Layout	Reference data
Size	N/A
Repeats	0 - Many
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	Reported for OHS Staff and OHS visitor records
Reported When	Reported when an incident has been closed.
Code set	Code set below see section 7 for a list of codes and descriptions. **developsafeworkprocedure/sops** **review/reinstructonexistingsafeworkprocedure** **providetraining** **replace/repairequipment/sourcenewequipment** **improvehousekeeping** **improvelayout/accessofworksite** **develop/reviewbehavioursupportplan** **appropriatepersonalprotectiveequipment** **completeriskassessment** **reviewworkprocess** **reviewclientriskprofile** **other-please specify**
Reporting Guide	Report the appropriate code/s representing the type of preventative or corrective action that was undertaken to mitigate the cause of the cause of the incident.
Validations	*Preventative/corrective action type* is mandatory for OHS incidents when *Date closed* is present. If *Preventative/corrective action type* is reported, *Preventative/corrective action status* and *Preventative/corrective action ID* are mandatory.

Related Elements	*Date closed* *Incident type* *Preventative/corrective action id* *Preventative/corrective action reason not achievable* *Preventative/corrective action status* *Preventative/corrective action completion date*

Administration

Purpose	Enables monitoring of trends in review and management of incidents.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019-20
Definition Source	Department of Health
Code Set Source	Department of Health

Review status

Specifications

Definition	Status of review for a reported incident
Label	reviews/*/status
Form	String
Layout	Reference data
Size	N/A
Repeats	Yes
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	All records.
Reported When	Reported at any time in the process of incident review.
Code set	**7** Open **8** Under review **9** Completed
Reporting Guide	Multiple review types can be reported, and statuses should be reported for each review type.
Validations	*Review status* is mandatory for all incidents when *Review type* is not ‘No review process undertaken’.

Related Elements	*Date closed* *Review ID* *Review type*

Administration

Purpose	Enables identification of impacted patient/workforce population for review, analysis, monitoring and reporting.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019–20
Definition Source	Department of Health
Code Set Source	Department of Health

Review type

Specifications

Definition	Type of review undertaken when investigating an incident	
Label	reviews/*/type	
Form	String	
Layout	Reference data	
Size	N/A	
Repeats	Yes	
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.	
Reported For	All records.	
Reported When	Reported at any time in the process of incident review.	
Code set	**linemanagerreview**	Line manager review
	aggregatereview	Aggregate review
	indepthcasereview	In depth case review
	rootcauseanalysis(rca)	Root cause analysis
	ohsreview	OHS review
	noreviewprocessundertaken	No review process undertaken
	otherreview	Other review
Reporting Guide	Multiple review types can be reported for an incident. For further information on review types see *Adverse Patient Safety Event Guidelines Safer Care Victoria*	

Validations	*Review type* is mandatory for all incidents when *Date closed* is present. If *Review type* is reported and not 'No review process undertaken', *Review status* and *Review ID* are mandatory.
Related Elements	*Date closed* *Review ID* *Review status*

Administration

Purpose	Enables identification of impacted patient/workforce population for review, analysis, monitoring and reporting.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019–20
Definition Source	Department of Health
Code Set Source	Department of Health

Reporter role

Specifications

Definition	Role of the staff member reporting the incident.
Label	Reporters_role
Form	String
Layout	Free text
Size	200
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	All record types.
Reported When	Reported at the transmission of a new incident.
Code set	Free text organisation determined code set
Reporting Guide	Roles are determined by the health service. Report most appropriate role.
Validations	*Reporter role* is mandatory for all incidents at first transmission.
Related Elements	*Is reporter the affected staff member?* *Worker role*

Administration

Purpose	Enables identification of impacted patient/workforce population for review, analysis, monitoring and reporting.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019–20
Definition Source	Department of Health
Code Set Source	Department of Health

Required level of care

Specifications

Definition	The level of care required by the staff member or visitor affected by an OHS incident.
Label	level_of_care
Form	String
Layout	Reference data
Size	256
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	All OHS (staff) and OHS (visitor) records.
Reported When	Reported at the transmission of a new incident. Can be amended throughout the process of incident review until closure.
Code set	**19** No care required **21** Assessment **20** First aid **22** Medical treatment **23** Inpatient hospital admission
Reporting Guide	One of three questions used to determine the Incident Severity Rating for an OHS (staff) or OHS (visitor) incident. **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

Required treatment is mandatory for all OHS incidents when *Date closed* is present.

Related Elements

Incident Type

Level of harm sustained.

Actions required

Administration

Purpose

One of three questions used to determine the staff and visitor OH&S Incident Severity Rating. See ISR in Section 2

Principal Data Users

Safer Care Victoria and Department of Health

Collection Start

2019–20

Definition Source

Department of Health

Code Set Source

Department of Health

Sentinel event

Specifications

Definition

An identifier for clinical incident indicating type of sentinel event that occurred.

Label

sentinel_event

Form

String

Layout

Reference data

Size

256

Repeats

N/A

Reported by

All Victorian public health services and all services under their governance structure including community health and bush nursing centres.

Reported For

Clinical records

Reported When	Reported at any time in process of incident review.	
Code set	**11**	Not a sentinel event
	12	1. Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death.
	13	2. Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death.
	14	3. Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death.
	15	4. Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death.
	16	5. Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death.
	17	6. Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward.
	18	7. Medication error resulting in serious harm or death.
	19	8. Use of physical or mechanical restraint resulting in serious harm or death.
	20	9. Discharge or release of an infant or child to an unauthorised person.
	21	10. Use of an incorrectly positioned oro- or naso- gastric tube resulting in serious harm or death
	22	11. All other adverse patient safety events resulting in serious harm or death
Reporting Guide	Only reported for clinical incidents where ISR is 1 or 2. Single response only. Report the most appropriate category. Please refer to the Victorian Sentinel Events Guide (2019) <https://www.safercare.vic.gov.au/best-practice-improvement/publications/sentinel-events-guide>	
Validations	*Sentinel event* is mandatory for all clinical incidents with an ISR of '1' or '2' when *Date closed* is present.	
Related Elements	*Incident type* *ISR (Derived)* *Date closed.*	

Administration

Purpose	Enables reconciliation with Sentinel event reporting.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019−20

Version History	Version	Previous Name
	1	Is this one of the following sentinel events?
Definition Source	Safer Care Victoria	
Code Set Source	Safer Care Victoria	

Sex (formerly Gender)

Specifications

Definition	The sex of the person
Label	sex(gender)
Form	String
Layout	Reference data
Size	256
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	Clinical incident records
Reported When	Reported at the transmission of a new incident.
Code set	**female** Female **male** Male **other** Other **unknown** Unknown
Reporting Guide	*Male and Female* A person's sex is usually described as either being male or female. Some people may have both male and female characteristics. Sex is assigned at birth and is relatively fixed. A person's sex may change during their lifetime as a result of procedures known alternatively as sex change, gender reassignment, transsexual surgery, or transgender reassignment. Throughout this process, which may be over a considerable period of time, sex could be recorded as either Male or Female. *Unknown* Used for infants with ambiguous genitalia, where the biological sex, even following genetic testing, cannot be determined. This code should not generally be used on data collection forms completed by the respondent. Only be assigned for infants aged less than 90 days. *Other* Includes:

	• An intersex person, who because of a genetic condition was born with reproductive organs or sex chromosomes that are not exclusively male or female. • A person who identifies as neither male nor female. Excludes: Transgender, transsexual and chromosomally indeterminate individuals who identify with a particular sex (male or female).
Validations	*Sex* is mandatory for all clinical incidents when *Date closed* is present.
Related Elements	*Date closed* *Incident type*

Administration

Purpose	Enables classification of incidents into categories, for review, analysis, monitoring and reporting.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019−20
Definition Source	Department of Health
Code Set Source	Department of Health

Specialty unit type

Specifications

Definition	The type of specialty unit or community health program responsible for the care of the impacted patient/client/consumer/resident, or the clinical area, community health program or non-care related function, where the impacted staff member was undertaking their role.
Label	specialty_type
Form	String
Layout	Reference data
Size	256
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	All records.
Reported When	Reported at the transmission of a new incident.

Code set	Specialty unit type code list (see Section 7- Code set list)
Reporting Guide	All *Specialty unit type* codes transmitted to VHIMS for incident created in VHIMS MDS 2024–25 must use a Specialty unit type code from the Specialty unit type code set list. **Clinical Incidents**: The type of specialty unit that is responsible for the care of the patient/client/resident/consumer that is harmed in the incident, often a medical specialty or a funded program. **OH&S and Hazard Incidents**: The type of specialty unit, community health program or non-care related activity which takes place where the staff member was impacted, often a medical specialty, workgroup or function, or a funded program. If an incident occurs where more than one Specialty Unit type could be allocated, a 'best fit' approach should be used. While an *Other* code has been provided, health services are encouraged to only use this code in the case where there is no match in the *Specialty unit type* list. The department will monitor the use of '*Other'* and will work closely with health services to ensure this list includes all possible specialty units.
Validations	*Specialty unit type* is mandatory for all incidents when *Date closed* is present.
Related Elements	

Administration

Purpose	Enables identification of impacted patient/workforce population for review, analysis, monitoring and reporting.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2024–25
Definition Source	Department of Health
Code Set Source	Department of Health

Type of injury

Specifications

Definition	Type of injuries sustained from the incident.
Label	type_of_injury
Form	String
Layout	Reference data
Size	256
Repeats	N/A

Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	All OHS (staff) and OHS (visitor) records.
Reported When	Reported at the transmission of a new incident. Can be amended throughout the process of incident review until closure.
Code set	Code set below see section 7 for a list of codes and descriptions. **abrasion/cut/laceration/puncture** **allergy/infection** **bruise/contusion** **burn/scald** **dislocation/fracture/crushing** **emotional/psychological** **lossofconsciousness(loc)/concussion/fainting** **skindisorder** **sprains/strains** **toxiceffects/poisoning** **redness/swelling**
Reporting Guide	Used to identify the type of injury from the list of available values when a worker or visitor was harmed as a result of the incident.
Validations	Reported for all OHS (staff) and OHS (visitor) records where *Level of harm sustained* is reported as 17 (Harm) or 18 (Death). *Type of injury* is mandatory when *Date Closed* is present and the above criteria are met.
Related Elements	*Incident type* *Level of harm sustained.* *Level of Care*

Administration

Purpose	Enables analysis of OH&S staff and visitor incidents.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019–20
Definition Source	Department of Health
Code Set Source	Department of Health

Ward/location type

Specifications

Definition	Code identifying the type of place where the incident occurred, or where the hazard was identified.
Label	ward_type
Form	String
Layout	Reference data
Size	256
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	All records.
Reported When	Reported at the transmission of a new incident.
Code set	Ward/location type code list (see Section 7 Code set list)
Reporting Guide	All *Ward/location type* codes transmitted to VHIMS for incident created in VHIMS MDS 2024–25 must use a Ward/location type code from the Ward/location type code set list. The *Ward/location Type* should identify the clinical environment or the type of location where the incident occurred. For example: • if the incident occurs in a ward in an acute hospital campus the ward type would be acute ward. • if the incident occurred in a clinical space of the same hospital, it would be recorded as having occurred in a clinical space. Where multiple Ward type/Location options are applicable to an incident, a 'best fit' approach should be used. While an *Other* code has been provided, health services are encouraged to only use this code in the case where there is no match in the Ward/location type list. The department will monitor the use of '*Other'* and will work closely with health services to ensure this list includes all possible ward/location types.
Validations	*Ward/location type* is mandatory for all incidents when *Date closed* is present.
Related Elements	*N/A*

Administration

Purpose	Enables identification of the type of location where the incident occurred, for review, analysis, monitoring and reporting.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2024–25
Definition Source	Department of Health
Code Set Source	Department of Health

Was open disclosure conducted?

Specifications

Definition	An indicator identifying if open disclosure has been conducted for the reported incident.
Label	is_open_disclosure
Form	Boolean string
Layout	“yes” / “no”
Size	N/A
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	Clinical records.
Reported When	Reported at any time in the process of incident review.
Code set	**yes** Yes **no** No **notapplicable** 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. **Yes** The reported incident meets the criteria and open disclosure has been undertaken **No** The reported incident meets criteria but open disclosure has not been undertaken at time of incident entry. **Not Applicable** The reported incident does not meet the requirements for open disclosure
Validations	*Was open disclosure conducted?* is mandatory for all clinical incidents when *Date closed* is present.

Related Elements	*Date closed* *Incident type*

Administration

Purpose	Enables analysis of open disclosure.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019-20
Definition Source	Department of Health
Code Set Source	Department of Health

Where did the incident occur?

Specifications

Definition	An indicator of the type of workplace location the OHS incident occurred.
Label	where_incident_occur
Form	String
Layout	Reference data
Size	256
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	OHS Staff records
Reported When	Reported at any time in the process of incident review.
Code set	**attheworkplace** — At the workplace **whentravellingaspartofthejob** — When travelling as part of the job **workingawayfromusualworkplace** — Working away from usual workplace **whentravellingto/fromwork** — When travelling to and from work
Reporting Guide	Select the appropriate option that best describes where the incident took place
Validations	*Where did the incident occur?* is mandatory for OHS (Staff) incidents when *Date closed* is present.

Related Elements	*Date closed* *Incident type*

Administration

Purpose	Enables analysis of OHS incidents
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019-20
Definition Source	Department of Health
Code Set Source	Department of Health

Worker role

Specifications

Definition	Role of the staff member affected by the incident.
Label	affected_staff_member_role
Form	String
Layout	Free text
Size	200
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	OHS Staff records.
Reported When	Reported at transmission of new incident when *Is the reporter the affected staff member* is reported as “no”
Code set	Free text organisation determined code set
Reporting Guide	Roles are determined by the health service. Enter most appropriate role.
Validations	*Worker role* is mandatory for OHS (Staff) incidents where *Is reported the affected staff member? i*s reported as ‘no” and *Date closed* is present.
Related Elements	*Date closed* *Incident type* *Is reporter of the incident the affected staff member?* *Reporter role*

Administration

Purpose	Enables identification of impacted patient/workforce population for review, analysis, monitoring and reporting.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019–20
Definition Source	Department of Health
Code Set Source	Department of Health

Section 3b: Data Definitions – Technical and Transmission elements

API release date

Specifications

Definition	Date identifying the specific API release that is being used to report an incident
Form	string
Layout	yyyy-mm-dd
Size	10
Repeats	N/A
Mandatory	Yes
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	All records.
Reported When	Reported as a query parameter in transmission.
Code set	N/A
Reporting Guide	Used to determine the API release version to be used for the reported record
Validations	N/A
Related Elements	*N/A*

Administration

Purpose	Used as a query parameter to determine the API version that the incident was created in and to ensure appropriate reference data is provided to validate the incidents
Principal Data Users	Department of Health
Collection Start	2019–20
Definition Source	Department of Health
Code Set Source	N/A

As of

Specifications

Definition	Transmission element - Query parameter The date time for which the reference data is required, so that the correct values that were effective at that time are retrieved. If not provided, the current date time is assumed.
Form	String
Layout	dateTime format, As defined by date-time - RFC3339
Size	NA
Repeats	N/A
Mandatory	No
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres.
Reported For	All records.
Reported When	Reported at transmission of new incident.
Code set	N/A
Reporting Guide	Optional data element that if reported determines the appropriate reference data that was available at the time of incident creation. If this element is not included as part of the transmission the data base will assume that the current reference data should be used to validate the reported incident.
Validations	N/A
Related Elements	*Incident date* *Age*

Administration

Purpose	To determine the reference data used to validate an incident.
Principal Data Users	Department of Health
Collection Start	2019–20
Definition Source	Department of Health
Code Set Source	N/A

Grouping ID

Specifications

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	GUID
Layout	System generated code e.g.: 0b4b484c-ef87-4f71-a31b-1bc8ac45d369
Size	
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres reporting via the VHIMS API.
Reported For	All records.
Reported When	Reported at any time in the process of clinical incident review.
Code set	N/A.
Reporting Guide	A system-generated item used to link related incident reports created in the incident management system.
Validations	*N/A*
Related Elements	*N/A*

Administration

Purpose	Enables grouping of incidents where multiple incidents have been generated from one situation.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019−20

Definition Source	Department of Health
Code Set Source	System generated GUID (health service software).

Incident ID

Specifications

Definition	DH generated unique identifier for incidents.
Form	GUID
Layout	System-generated code
Size	N/A
Repeats	N/A
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres
Reported For	All transmitted records
Reported When	System Generated by Department of Health following transmission
Code set	N/A
Reporting Guide	Department of Health generated id for all reported incidents
Validations	N/A
Related Elements	N/A

Administration

Purpose	Unique identifier for all transmitted incidents used in VHIMS reporting.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	20219−20
Definition Source	Department of Health
Code Set Source	Department of Health

Preventative/corrective action ID

Specifications

Definition	Unique identifier for a preventative or corrective action.
Label	preventative_corrective_actions/*/id
Form	GUID

Layout	System-generated
Size	N/A
Repeats	Yes
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres
Reported For	All OHS staff and OHS visitor records
Reported When	Reported when a *Preventative/corrective action* is first transmitted and with every message where this *Preventative/corrective action* is updated.
Validations	*Preventative/corrective action ID* is mandatory for OHS incidents when *Preventative/corrective action type* is not null and *Date closed* is present.
Related Elements	*Incident type* *Preventative/corrective action completion date* *Preventative/corrective action reason not achievable* *Preventative/corrective action status* *Preventive/corrective action type* *Date closed*
Code set	*N/A*
Reporting Guide	This needs to be a globally unique identifier, so that updates of existing actions can be distinguished from additions of new actions

Administration

Purpose	To allow multiple *Preventative/corrective actions* to be reported and updated independently for each incident.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019–20
Definition Source	Department of Health
Code Set Source	Department of Health

Review ID

Specifications

Definition	Unique identifier for a review
Label	reviews/*/id

Form	GUID
Layout	System-generated code
Size	N/A
Repeats	Yes
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres
Reported For	All records
Reported When	Reported when a review type is first transmitted and with every message where Review *type* and *Review status* are updated.
Validations	*Review ID* is mandatory for all clinical incidents when *Review type* is not 'No review process undertaken'.
Related Elements	*Review Type* *Review Status*
Code set	*N/A*
Reporting Guide	This needs to be a globally unique identifier, so that updates of existing actions can be distinguished from additions of new actions

Administration

Purpose	To allow multiple review types to be reported and updated independently for each incident.
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019–20
Definition Source	Department of Health
Code Set Source	Department of Health

Request Date and Time (API header element)

Specifications

Definition	Timestamp of when the API request was made. .
Form	String
Layout	yyyy-mm-ddThh:mm:ss:fffZ
Size	
Repeats	N/A

Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres
Reported For	All record types
Reported When	Reported on transmission of an incident via the API
Validations	N/A
Related Elements	*N/A*
Reporting Guide	Reported in the header section of reported incidents when transmitted via the API.

Administration

Purpose	Required for transmission of incidents via the API
Principal Data Users	Safer Care Victoria and Department of Health
Collection Start	2019–20
Definition Source	Department of Health
Code Set Source	Department of Health

Section 4: Business rules

Introduction

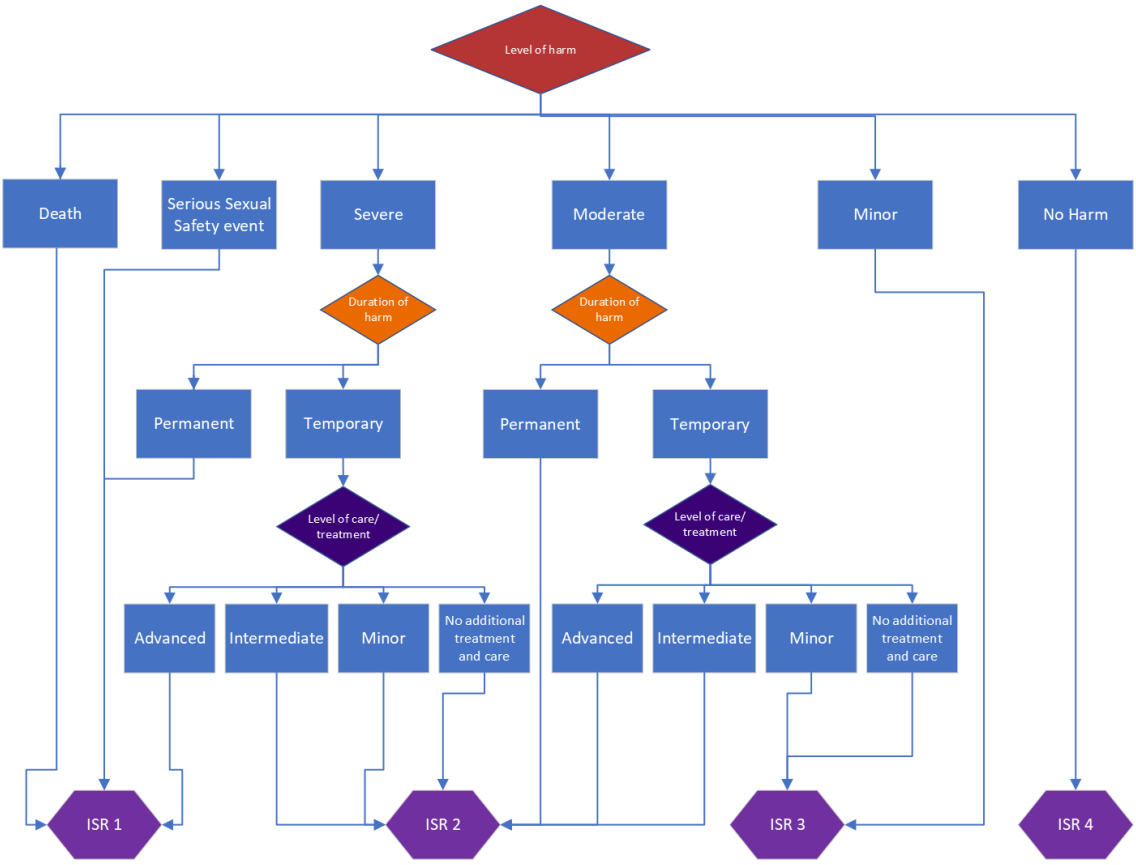
This section provides business rules associated with reporting to the VHIMS MDS data collection. The business rules relate both to the various data items, as well as providing technical information associated with reporting to the VHIMS MDS.

Clinical Incident Severity Rating Algorithm

In VHIMS MDS v2 (VHIMS MDS version 2) changes have been made to the clinical Incident Severity Rating (ISR) algorithm.

All clinical records reported following the implementation of VHIMS MDS v2 at any health service must define ISR using this algorithm. Incidents reported using VHIMS MDS version 1, VHIMS MDS 2023-24 and earlier will derive ISR using the version 1 algorithm. Three new questions have been added to the MDS for VHIMS MDS v2

- Level of Harm clinical
- Duration of Harm
- Level of treatment/care



Please refer to Section 7 for further information on ISR algorithm

Health services should refer to *Clinical Incident Severity Rating (ISR): Guidance for health services reporting the VHIMS MDS v2*. for assistance with implementation of the new ISR.

De-identification of information

Health services should ensure that data fields containing descriptive information do not contain any identifiable details to meet confidentiality and privacy standards as outlined in relevant Commonwealth and State law. Ensuring that the personal information of health service patients, visitors and staff is protected..

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 descriptions, 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.

The continued inclusion of descriptive fields such as Brief summary and Details in the VHIMS MDS is currently under review, during this time health services are not required to send the descriptive details in the VHIMS MDS transmission. However as this information is included in investigation reports required by the department for certain incident types , health services should ensure these fields are deidentified.

Elements required when transmitting new incident

There are several elements that at the department requires at incident transmission. These elements are required to classify and group incidents. Health services should work with their vendors to ensure the collection and transmission of these elements for all new incident records, including ensuring these elements are mandatory in their system front-end for creation of all new incident.

Element	Clinical	OHS (Staff)	OHS (Visitor)	Hazard
Action required		✓		
DH campus code	✓	✓	✓	✓
Duration of harm	✓			
Event type	✓	✓	✓	✓
HS incident id	✓	✓	✓	✓
Incident date	✓	✓	✓	✓
Incident grouping identifier	✓	✓	✓	✓
Incident time	✓	✓	✓	✓

Level of care/treatment	✓			
Level of disruption				✓
Level of harm	✓			
Level of harm sustained		✓	✓	
Level of impact				✓
Level of interventions				✓
Notification date	✓	✓	✓	✓
Organisation id	✓	✓	✓	✓
Reporters role	✓	✓	✓	✓
Required level of care		✓	✓	
Specialty unit type	✓	✓	✓	✓
Ward location type	✓	✓	✓	✓

Incident Date

Health services should take care when reporting Incident date. Incident date is used in derivation of Age and is important in the reporting of process measures. Reporting of Incident date should adhere to the following business rules:

1. *Incident date* should not be after *Notification date*.
2. While it is legitimate that an incident date can be in the past, care must be taken with incident dates in the distant past. Health services should implement a process for reviewing all incident dates that are more than 5 years earlier than the incident *Notification date* to ensure they are correct. Data analysis by eHealth has identified multiple examples of incident dates where *Date of Birth* rather than incident date has recorded.

Open Disclosure and Statutory Duty of Candour

The Australian Open Disclosure Framework should be included as part of any incident management process. Recording of open disclosure within the VHIMS MDS ensures monitoring on a state-wide level to identify gaps in this process, guiding the need for increased resources or training at a health service level.

Statutory Duty of Candour (SDC) came into effect November 2022 following legislative changes. Relevant health services are required to provide a patient with a Statutory Duty of Candour (SDC) when they have suffered a serious adverse patient safety event (SAPSE) while receiving health

services. The SDC builds on the principles and elements of open disclosure within the Australian Open Disclosure Framework.

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. Please refer to the Safer Care Victoria Adverse Patient Safety Event Policy for further information about requirements for reporting APSEs

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.

Community Health Services are encouraged to report in near real time. However, the mandatory requirement to report has not been implemented Until this change Community Health services must continue to follow the requirements of the Critical Incident Pathway.

- Refer to Section 5 for guidance on VHIMS MDS transmission requirements
- 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 are 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.

When is an incident considered closed?

An incident should be closed when the following has occurred.

- The incident has been reviewed by a manager to ensure description of the event is accurate and objective, and free text field contain no identifying information.
- The appropriate review for the confirmed Incident Severity Rating (ISR) in line with health service policy.
- Where required, open disclosure has been undertaken and recorded. Where there has been a Serious Adverse Patient Safety Events (SAPSE),a statutory duty of candour process has commenced.

- 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 and for community health services, notification to the appropriate department of health program area in line with the Critical Incident Reporting Pathway
- Feedback is provided to the incident reporter to assure the report has been reviewed and actioned, thereby 'closing the loop'.

Health services should have a local process to monitor and close the loop on outstanding recommendations must be in place prior to the incident closure.

Section 5: Compilation and submission

This section provides an overview of how the VHIMS MDS is transmitted to the department.

Health services are required to submit incident data (new incident records as well as updates to existing incident records) electronically daily in near real time.

There are two ways that health services can meet their VHIMS MDS reporting requirements with the departments web-based application VHIMS CS, or via the Incident Management System Application Programming Interface (IMS API).

VHIMS CS reporting,

Incident data from health services is automatically transmitted to the department There is no additional transmission process health service are required to undertake to meet their reporting requirements.

VHIMS IMS API reporting

Health services that are not using VHIMS CS are required to source and maintain an incident management system (IMS) from a vendor with capability to report the VHIMS MDS via the Incident Management System Application Programming Interface (IMS API)

Health services will record and manage incidents in their local system and incidents will be automatically or manual submitted to the department, Health services should work closely with their vendor to ensure that they meet their VHIMS MDS reporting requirements.

IMS API/health-service-incident/v2 API Specifications are available for vendors wishing to report VHIMS MDS. This document provides an end-to-end process of reporting via the IMS API

Section 6: Validation

This section describes the action to be taken by health services when a validation is encountered on transmission. It is relevant to health services reporting VHIMS MDS via the IMS API

Health services using VHIMS CS will not receive these validation errors because the validations are built into the application, preventing the type of errors below from occurring.

Successful transmissions will result in a status code of 200 indicating that the transmission has been accepted

Error messages will have the following status codes

Status code	Description
400	Bad Request- This is an application error that is raised by the API and will include a message with additional information that will assist health services is identifying what information is missing from the transmitted file.
401	Unauthorised
403	Forbidden
404	Not found
405	Method not allowed
408	Request timeout
415	Unsupported media type
500	Internal Server Error

Example validations

Error code	Message	Cause	Resolution
400- 100	Invalid request. The value '85b9b52c-9a8b-444d-9dd0-bc9d196f1e0h' is not valid.	An invalid identifier was transmitted in the file	Work with your vendor to identify why the incorrect id has been sent in the transmission
400-101	Invalid date format (expected \"yyyy-MM-dd\", e.g.: \"2018-12-31\"",	The date used in the file did not match the format required	Work with your vendor to ensure that dates are formatted and transmitted as outlined in the API specifications
400-101	The value provided is not supported	A value has been transmitted which is not a value allowed in the VHIMS MDS version	Work with your vendor to ensure that dates are formatted and transmitted as outlined in the API specifications
400-101	Incident not found	An incident has been sent as an update message, however there is no record of this incident in the system	Work with your vendor to investigate why the incident was not accepted by the department
400-101	Health service incident identifier (HSIncidentID) is required when transmitting new incidents	A Health service identifier for the reported incident was not provided	Ensure HSIncidentID for the reported incident is included in transmitted record

Section 7 Code lists (includes Event type taxonomy)

Section 7 includes all the values in lists that are too long to be included in the section 3 of the manual. The table below outlines the lists. Section 7 is available for download.

1	VHIMS MDS v2	Main List - page includes the following lists: • Body parts, • Contributing factors, • Preventative/corrective action types, • Specialty Unit Types, • Ward/Location Type.
2	DH Campus Code List	DH Campus code list contains all the campus codes for each hospital as they appear in the departments administrative collections including Agency Information Management System (AIMS), VINAH and Community Health Services (Updated 8/11/2024 to reflect changes to CHMDS)
3	Event taxonomy Clinical	A list of all the event types including subcategories and questions for clinical incident reporting
4	Event taxonomy - OHS-Staff	A list of all the event types including subcategories and questions for OH&S (staff) incident reporting
5	Event taxonomy - OHS Visitor	A list of all the event types including subcategories and questions for OH&S(visitor) incident reporting
6	Event taxonomy - Hazard	A list of all the event types, subcategories and questions for hazard incident reporting
7	ISR Algorithm v2	A matrix representation of the Incident Severity Rating (ISR) algorithm for each incident type reported using current version, VHIMS MDS v2
8	ISR Algorithm v1	A matrix representation of the Incident Severity Rating (ISR) algorithm used for all Incident type reported using the, VHIMS MDS v1

References

Department of Health. (2024, July 15). *Incident reporting for Community health services*. Retrieved from Health.vic.gov.au: https://www.health.vic.gov.au/incident-reporting-community-health-services

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