

Form for the identification of incidents and AE in Primary Care

DATA OF THE CENTER

Select the centre

☐ xxxx

DATA OF THE NOTIFIER

Professional category:

- ☐ doctor ☐ paediatrician ☐ gynaecologis
☐ resident doctor
☐ nurse ☐ midwife ☐ Health technician
☐ Social worker
☐ Administrative*
☐ Administrative assistant*
☐ Caretaker*
☐ Nursing technician*

Work experience:

- ☐ Less than 1 year
☐ From 1 to 5 years
☐ From 5 to 10 years
☐ More than 10 years

* Professionals in these categories must proceed to question n. 3 of the questionnaire

INCIDENT RELATED TO:

- ☐ Assistance
☐ Environment of care (no patient directly related to the incident)

PATIENT DATA

Administrative data

Identification:

Age:

Gender: ☐ man ☐ woman

Date of notification:

Date of event:

Clinical data

1. Patient characteristics

☐ PCC ☐ MACA ☐ FRAGILE ☐ GMA 1 ☐ GMA 2 ☐ GMA 3 ☐ GMA 4 ☐ GMA 5

2. Indicate if the patient has any of the following risk factors

INTRINSIC Factor

- | | | |
|---|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Hypoalbuminemia | <input type="checkbox"/> Pressure ulcer |
| <input type="checkbox"/> Liver cirrhosis | <input type="checkbox"/> Immunodeficiency | <input type="checkbox"/> Neoplasia |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Neutropenia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Renal failure | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Hypercholesterolemia | <input type="checkbox"/> Chronic lung disease | <input type="checkbox"/> Others: _____ |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Malformations | |

EXTRINSEC Factor

- ☐ Colostomy ☐ Open urinary catheter ☐ Tracheotomy
☐ Enteral nutrition ☐ Closed urinary catheter
☐ Other: _____
☐ Nasogastric tube ☐ Immunosuppressive therapy _____

DESCRIPTION OF THE INCIDENT

3. Summarize what happened and what caused it: _____

4. At what level of care did the problem occur?

(Tick only one option)

- ☐ Medical transport
☐ Community care
☐ Urgent care in Primary Care
☐ ASSIR queries
☐ Consultations of specialized care
☐ Primary care nursing consultations
☐ Primary Care medical consultations
☐ Home address
☐ General spaces
☐ Previous hospital admission
☐ Laboratory
☐ Pharmacy warehouse
☐ Material warehouse
☐ Community pharmacy office
☐ Residence
☐ Nursing technical room
☐ Citizen attention desk
☐ Hospital emergencies
☐ Administrative area
☐ Others: _____

5. Type of visit

- ☐ Attended
☐ Not in person
☐ Home address

RISK MATRIX

6. Likelihood of happening

(Tick only one option)

- ☐ Frequent (It is expected to happen again in the coming weeks or months)
☐ Probable (Can happen under various circumstances, several times a year)
☐ Possible/Occasional (May reoccur or occur once or twice a year)
☐ Infrequent (Could happen sometime every 2 to 5 years)

- ☐ Very infrequent (Unlikely to recur – may occur only in exceptional circumstances, more than 5 years)

7. Which of these statements best describes the impact on the patient?

(Tick only one option)

If you check the option "notifiable circumstance, near incident or incident without damage", answer question 8 and go to question 14

☐ **Incident that does not reach the patient:**

- ☐ Reportable circumstance (effect has not happened, but was about to happen)
- ☐ Near miss (the incident has occurred, but was detected before it affected a patient)

☐ **Incident that reaches the patient without harm:**

- ☐ Non-harm incident (the incident happened and affected a patient, but the patient was not harmed)

☐ **Incident that reaches the patient and causes harm (Adverse Event):**

- ☐ The effect has passed and the patient required observation
- ☐ The effect has worn off and the patient has taken temporary damage
- ☐ The effect has passed and the patient has been in a critical situation (Ex.: cardiac arrest)
- ☐ The effect has worn off and the patient has suffered permanent damage
- ☐ The effect has passed and the result has been the death of the patient

CONTRIBUTING FACTORS

8. Contributing factors related to:

☐ Patient-related factors

- ☐ Distraction or lack of attention
- ☐ Failure to comply with rules / orders / instructions given by the professional
- ☐ Escape or disappearance
- ☐ Misinterpretation of information
- ☐ Clinical complexity / Associated diseases
- ☐ Communication problems
- ☐ Existence of emotional factors
- ☐ Negative attitude / Absence of collaboration
- ☐ Risk behaviour
- ☐ Aggression / Hostility
- ☐ Self-harm / autolysis (suicide: attempt or consummation)
- ☐ Emergency care situation / Severity
- ☐ Transfer / Displacement / Transitions...
- ☐ Sensory limitations

☐ Factors related to the professional

- ☐ Distraction or lack of attention
- ☐ Fatigue or exhaustion
- ☐ Failure to comply with rules / orders / directions
- ☐ Technical error: slip, oversight or error
- ☐ Incorrect selection of available alternatives
- ☐ Communication on paper
- ☐ Verbal communication
- ☐ Excessive attention to an item / action / circumstance
- ☐ Overconfidence
- ☐ Lack of specific skills
- ☐ Ignorance of specific information
- ☐ Incorrect application of rules / protocols
- ☐ Misinterpretation of information
- ☐ Electronic communication
- ☐ Communication problems with another professional
- ☐ Existence of emotional factors
- ☐ Existence of social factors

☐ Factors of the physical environment

- ☐ Infrastructures
- ☐ Remote or very distant from the service
- ☐ Environmental risk assessment or safety assessment
- ☐ Current code, specifications or regulations
- ☐ Equipment

☐ Service organization factors

- ☐ Protocols, guidelines, policies, procedures or processes
- ☐ Organizational decisions or culture
- ☐ Organization of teams
- ☐ Resources or workload
- ☐ Availability of operating rooms, beds for income or others
- ☐ Staff availability
- ☐ Organization of teams

- ☐ Access to updated protocols, procedures or circuits
- ☐ **External factors**
 - ☐ Natural environment
 - ☐ Products, technology and infrastructure
 - ☐ Services, systems and policies

CAUSAL FACTORS OF THE ADVERSE EVENT

9. Indicate all causal factors of the adverse event (Risk Map)

Related to medication

- ☐ Adverse drug reaction
- ☐ Medication errors
 - ☐ Incorrect dosage
 - ☐ Incorrect treatment duration
 - ☐ Dispensing error (Community Pharmacy Office)
 - ☐ Preparation or manipulation error (Different route of administration)
 - ☐ Lack of adherence to treatment
 - ☐ Incorrect frequency of administration
 - ☐ Drug interaction
 - ☐ Expired medication
 - ☐ Wrong medication
 - ☐ Insufficient monitoring
 - ☐ Patient denial
 - ☐ Omission of dose, medication or vaccine
 - ☐ Wrong patient
 - ☐ Prescription NOT effective
- ☐ vaccines
 - ☐ Stock and order management
 - ☐ Reception
 - ☐ Conservation and storage
 - ☐ Preparation
 - ☐ Administration CAP
 - ☐ School administration
 - ☐ Calculation problems
 - ☐ Registration issues (e-CAP)
 - ☐ Expired vaccines
- ☐ **Related to management**
 - ☐ Erroneous quote
 - ☐ Duplication of the clinical history
 - ☐ Mistake in health information
 - ☐ Patient identification error
 - ☐ Long waiting list
 - ☐ Loss of documents
 - ☐ Problems with computerized history
- ☐ **Related to diagnosis**
 - ☐ Error in diagnosis
 - ☐ Delay in referral to specialist care
 - ☐ Delay in diagnosis

☐ **Related to communication**

- ☐ Administrative-Administrative Communication
- ☐ Administrative Communication-nursing technician
- ☐ Administrative-Patient Communication
- ☐ Nursing-Administrative Communication
- ☐ Nurse-Nurse Communication
- ☐ Nurse Communication- nursing technician
- ☐ Nurse-Patient Communication
- ☐ Doctor-Administrative Communication
- ☐ Doctor- nursing technician communication
- ☐ Doctor-Nurse Communication
- ☐ Doctor-Doctor Communication
- ☐ Doctor-Patient Communication
- ☐ Communication with other devices
- ☐ Cultural barrier
- ☐ Language barrier

☐ **Related to patient care**

- ☐ Inadequate patient handling
- ☐ Inadequate handling of warning signs
- ☐ Inadequate handling of the technique
- ☐ Inadequate handling of the procedure
- ☐ Inadequate maintenance of catheters

☐ **others**

- ☐ Other causes: _____

EFFECTS OF THE ADVERSE INCIDENT

10. Indicate all the effects that occurred in the patient:

☐ **Related to a procedure**

- ☐ Hemorrhage or hematoma related to surgery or procedure
- ☐ Hematuria related to probing
- ☐ Circulatory disorder (tight splint)
- ☐ Dehiscence of sutures
- ☐ Serous, abscesses or granulomas
- ☐ Tympanic perforation
- ☐ Other complications due to a procedure

☐ **Related to Healthcare Associated Infections (HAIs)**

- ☐ Surgical and/or traumatic wound infection
- ☐ UTI associated with probing
- ☐ Device-associated bacteraemia
- ☐ Opportunistic infection due to immunosuppressive treatment or antibiotic use
- ☐ Pressure sore infection
- ☐ Aspiration pneumonia

☐ **Related to patient care**

- ☐ Phlebitis
- ☐ Pressure ulcer
- ☐ Burns, erosions, falls and bruises (including consequential fractures)
- ☐ Sciatica injury from injectable
- ☐ Other consequences of patient care

☐ **Generals**

- ☐ By evolutionary course of the underlying disease
- ☐ Need to repeat the procedure or visit
- ☐ Anxiety, stress or depression

☐ **Related to medication**

- ☐ Nausea, vomiting or diarrhoea secondary to medication
- ☐ Pain or discomfort due to drugs (epigastralgia)
- ☐ Itching, rash or skin lesions reactive to drugs or dressings
- ☐ Systematic allergic manifestations
- ☐ Drug headache
- ☐ Neurological changes due to drugs
- ☐ Constipation
- ☐ Other side effects (cough, dyspnoea, dry mouth,...)
- ☐ Hypotension due to drugs
- ☐ Poor blood pressure control
- ☐ Upper digestive bleeding
- ☐ Haemorrhage due to anticoagulation
- ☐ AMI, stroke, PE, DVT
- ☐ Electrolyte imbalance
- ☐ Edema, heart failure and shock
- ☐ Alteration of heart rhythm or electrical activity due to drugs
- ☐ Functional alteration (kidney, liver, thyroid,...)
- ☐ Poor glycaemic control
- ☐ Neutropenia
- ☐ Local effects or fever after vaccine or drug
- ☐ Poor pain management

☐ **Others**

- ☐ Other

consequences

☐ **No effect**

CONSEQUENCE OF THE ADVERSE EVENT

11. What care did the patient receive as a result of the adverse event?

- ☐ Health care was not affected
- ☐ It required a higher level of observation and monitoring in primary care
- ☐ Required an additional test (x-ray, analyses,...) in primary care
- ☐ Additional medical or surgical treatment (antibiotics, minor surgery,...) in primary care
- ☐ Required a new consultation or referral to Specialized Care or Emergency without admission
- ☐ Hospitalization required: life support treatment (orotracheal intubation, CPR, surgical intervention)

12. To what extent has healthcare been the cause of the injury?

(Tick only one option)

- ☐ Absent evidence that the incident is due to patient handling, the injury is entirely due to the patient's pathology
- ☐ Minimal likelihood that handling was the cause
- ☐ Slight chance that handling was the cause
- ☐ Moderate probability that handling was the cause
- ☐ Handling was most likely the cause

☐ Full evidence that the handling was the cause of the incident/adverse event

AVOIDABILITY

13. In your opinion, is there any evidence that AE could have been prevented?

☐ Yes ☐ No ☐ Doubtful

14. Evaluate the evidence of the possibility of prevention

(Tick only one option)

- ☐ Minimal possibility of prevention
- ☐ Slight possibility of prevention
- ☐ Moderate possibility of prevention
- ☐ High possibility of prevention
- ☐ Total evidence of the possibility of prevention

SUGGESTIONS FOR IMPROVEMENT

15. What could have been done to avoid this problem?

RESOLUTION

16. Who decides?

- ☐ Primary care team
- ☐ Unit of Patient Safety

TO BE COMPLETED BY THE UFSP

17. Type of incidents (MADS classification)

- ☐ Urgent care
- ☐ Continuity of care
- ☐ Education for health
- ☐ Ethics and citizens' rights
- ☐ Management of clinical material
- ☐ Waste Management
- ☐ Laboratory
- ☐ Care process
- ☐ Administrative processes
- ☐ Diagnostic Image Service
- ☐ General services (cleaning, infrastructure, security and techno-assistance devices)
- ☐ Social work
- ☐ Safer drug use
- ☐ Vaccines
- ☐ Surveillance, prevention and infection control

18. Quality of notification

(Tick only one option)

- ☐ Correct
- ☐ Disagreement

19. Who resolves the notification?

- ☐ Primary care team
- ☐ Assistance direction
- ☐ Pharmacy
- ☐ Laboratory
- ☐ Responsible citizenship
- ☐ Transverse Unit of Patient Safety
- ☐ Others

20. Safe practices and/or Unit of Patient Safety improvement actions

- ☐ Improving teamwork_new
- ☐ Improving teamwork_existing
- ☐ Training action (courses, workshop,...)
- ☐ Informative action (clinical session, mail,...)
- ☐ Commission/committee
- ☐ Review documents
- ☐ Analysis London

21. Safe practices and/or primary care team improvement actions

- ☐ Improving teamwork_new
- ☐ Improving teamwork_existing
- ☐ Training action (courses, workshop,...)
- ☐ Informative action (clinical session, mail,...)
- ☐ Committee/management
- ☐ Review documents
- ☐ Analysis London

22. status

- ☐ Solved
- ☐ Pending to solve territorial UFSP
- ☐ Pending to solve DAP
- ☐ Pending to fix other units