

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

- Alcoholism Hypoalbuminemia Pressure ulcer
 Liver cirrhosis Immunodeficiency Neoplasia
 Depression Heart failure Neutropenia
 Diabetes Renal failure Obesity
 Drug addiction Coronary artery disease HIV
 Hypercholesterolemia Chronic lung disease Others: _____
 Hypertension 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 (orotraqueal 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