Data Dictionary

Common Formats

Hospital Version 2.0

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Data Dictionary Field Definitions

Data Element Name:	A unique name assigned to each data element.
Data Element ISO Name:	Convention for naming Common Formats data elements and is based on the principles defined in the International Organization for Standardization (ISO) and International Electrotechnical Commission (IEC) 11179-5: 2005(E) standards. The format is Object_Qualifier-Property_Qualifier.
Data Element ID:	A unique alphanumeric identifer. All data elements begin with "DE".
Definition:	A statement that expresses the essential nature of a data element and its differentiation from all other data elements.
Version:	The identification of a data element specification in a series of evolving data element specifications.
Question:	The text used to express the data element as a question for data collection instruments.
Value Domain:	The set of representations of permissible instances of the data element, according to the representational form, layout, data type, and minimum size specified in the corresponding attributes. The set can be specified by name (such as existing classification schemes such as ICD9), by reference to a source, or by enumeration of the representation of the instances (for example, "Marital Status" values are M=Married, S=Single, D=Divorced). The last is termed an enumerated domain.
Maximum Length:	The maximum number of storage units (of the corresponding data type) necessary to represent the data element value. For a text field, the maximum length is the maximum number of storage units allowed.
Multiple Choice:	The identification of a single or multiple answer choice. Answer choice "Yes" indicates multiple answers are allowed. Answer choice "No" indicates that multiple answer choices are not allowed.
Format:	The manner in which data is captured, formatted, and displayed.
Data Type:	An attribute that specifies the type of data that the field can hold: numeric, character, date/time.
HL7 Data Type:	The kind of data that can be included in a field, and are used throughout the HL7 message structure. Examples would be a string, formatted text, timestamp, address, or coded element. Per the Technical Specifications: Resources Workbook, the following data types are used in the Common Formats: - Concept Descriptor (CD) - Encapsulated Data (ED) - Integer Number (INT) - Physical Quantity (PQ) - Person Name (PN) - Point in Time (TS) - Telecommunication Address (TEL)
Guide for Use:	Instructions or advice for the interpretation, use, or application of the data element.
References:	Reference to any document(s) (including web-sites), organizations or committees from which any content of the data element originates.
Collected in Module(s):	The Common Format module(s) on which the administered item is collected.
Comments:	Any general note providing additional information about the data element. This field could be used to capture miscellaneous information not captured elsewhere.
Description of Change:	Changes to the data element and its associated metadata attributes between the current and the previous version.
Rationale for Change:	Provides the reason for change to a data element.
Start Date:	The date the data element was released.
Update Date:	The date the data element metadata was last updated.

Administrative

Data Element Name:	**Provider ID**
Data Element ISO Name:	Provider-ID,ED
Data Element ID:	DE1
Definition:	PSO-assigned provider identifier.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What is the Provider ID?
Value Domain:	N/A
Maximum Length:	16
Multiple Choice:	No
Format:	Refer to Common Formats Resources Workbook (Validation Tab).
Data Type:	Character
HL7 Data Type:	Encapsulated Data (ED)
Guide for Use:	Each provider shall be identified at the PSO by a unique identifier. The PSO can assign an identifier to a provider that does not identify the actual provider.
References:	No specific reference at this time.
Collected in Module(s):	Administrative
Comments:	None defined at this time.
Description of Change:	Changed: -Question Text from "Provider ID" to "What is the Provider ID?"
Rationale for Change:	Question text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Event ID**
Data Element ISO Name:	Event-ID,ED
Data Element ID:	DE2
Definition:	Uniquely identifies each event report at the provider.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What is the Event ID?
Value Domain:	N/A
Maximum Length:	16
Multiple Choice:	No
Format:	Refer to Common Formats Resources Workbook (Validation Tab).
Data Type:	Character
HL7 Data Type:	Encapsulated Data (ED)
Guide for Use:	Each facility is required to assign a unique Event ID to each patient safety event or unsafe condition report. This Event ID will be used to uniquely identify an event or unsafe condition at the facility. It is important to ensure that the Event ID assigned to each event or unsafe condition is unique within the provider.
References:	No specific reference at this time.
Collected in Module(s):	Administrative
Comments:	None defined at this time.
Description of Change:	Removed: -Guide for Use text "The Common Formats Forms provide the ability to collect the Event ID on every form. When using the forms it is important to note that all forms pertaining to a single event report have the same unique Event ID." Changed: -Question text from "Event ID" to What is the Event ID?"
Rationale for Change:	Question text clarification and Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**PSO OID**
Data Element ISO Name:	PSO-OID,ED
Data Element ID:	DE4
Definition:	Unique identifier for the PSO.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What is the PSO ID?
Value Domain:	N/A
Maximum Length:	128
Multiple Choice:	No
Format:	Refer to Common Formats Resources Workbook (Validation Tab).
Data Type:	Character
HL7 Data Type:	Encapsulated Data (ED)
Guide for Use:	Each PSO shall be identified by a unique Object Identifier (OID). The unique OID for each PSO shall be created using a combination of the PSO Root OID (2.16.840.1.113883.3.263.1.5) and the PSO ID (e.g. P0023) assigned by AHRQ to each PSO. The AHRQ assigned unique PSO ID for each PSO begins with the letter P, followed by 4 numeric characters e.g. P0023. The PSO ID is assigned to the PSO upon official listing by AHRQ. The PSO shall create their PSO OID using the following convention: The numeric value (not including any preceding zeros) of the PSO ID is appended to the PSO Root OID (2.16.840.1.113883.3.263.1.5). The PSO Root OID and the numeric value of the PSO ID shall be separated by a period. For example, the PSO OID for a PSO with an AHRQ-assigned PSO ID of P0023 would be: 2.16.840.1.113883.3.263.1.5.23. For more information about OIDs refer to the HL7 OID registry at http://www.hl7.org/oid
References:	http://www.hl7.org/oid
Collected in Module(s):	Administrative
Comments:	None defined at this time.
Description of Change:	Changed: -Question text from "PSO ID" to "What is the PSO ID?"
Rationale for Change:	Question text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Anesthesia

Data Element Name:	**Physiologic complication of anesthesia**
Data Element ISO Name:	Anesthesia-Physiologic complication,CD
Data Element ID:	DE2000
Definition:	Determination if any of the following physiologic complications occurred: cardiac or circulatory event; central nervous system event; renal failure, impairment or insufficiency; respiratory failure.
Version:	Hospital Version 2.0
Question:	Which of the following physiologic complication(s) occurred that was not present prior to anesthesia?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A2088	Cardiac or circulatory event	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2091	Central nervous system event	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2094	Renal failure, impairment, or insufficiency	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2095	Respiratory failure	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A66	Other: Please specify	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	5 (2000 for free text associated with "Other: Please specify" response.)
Multiple Choice:	Yes
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Select "Other: Please specify" if the physiologic complication, not present prior to anesthesia, is not listed in the above answer values.
References:	No specific reference at this time.
Collected in Module(s):	Anesthesia
Comments:	None defined at this time.
Description of Change:	N/A
Rationale for Change:	N/A
Start Date:	5/18/2017
Update Date:	N/A

Data Element Name:	**Manifestation of respiratory failure**
Data Element ISO Name:	Respiratory failure-Manifestation,CD
Data Element ID:	DE2003
Definition:	Determination of the best description of how the respiratory failure was manifested.
Version:	Hospital Version 2.0
Question:	Which of the following best describes how the respiratory failure was manifested?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A2103	Prolonged ventilator support following anesthesia	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2106	Re-institution of ventilator support after discontinuance following anesthesia	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2107	Use of ventilator post-operatively only	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A66	Other: Please specify	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	5 (2000 for free text associated with "Other: Please specify" response.)
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only if the physiologic complication that occurred was “Respiratory failure.” Select the answer which, in your judgment, best describes how the respiratory failure was manifested. Select A2103 “Prolonged ventilator support following anesthesia” refers to ventilator support that is used during the procedure according to plan. Select A2106 “Re-institution of ventilator support after discontinuance following anesthesia” refers to ventilator support that, according to plan, is used during the procedure and is discontinued following the procedure. Select A2107 “Use of ventilator post-operatively only” refers to ventilator support that was not begun until after the termination of the operation. Select A66 “Other: Please specify” if the manifestation of respiratory failure is not listed among the above answer values.
References:	No specific reference at this time.
Collected in Module(s):	Anesthesia
Comments:	None defined at this time.
Description of Change:	N/A
Rationale for Change:	N/A
Start Date:	5/18/2017
Update Date:	N/A

Data Element Name:	**Type(s) of anesthesia and/or sedation**
Data Element ISO Name:	Anesthesia-Anesthesia and Sedation-Type,CD
Data Element ID:	DE2006
Definition:	Determination of the type(s) of anesthesia and/or sedation used.
Version:	Hospital Version 2.0
Question:	What type(s) of anesthesia and/or sedation was used?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A1965	General anesthesia	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1968	Regional anesthesia (e.g., epidural, spinal, or peripheral nerve blocks)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1971	Local or topical anesthesia	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1972	Sedation	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	5
Multiple Choice:	Yes
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Select the type(s) of anesthesia, or sedation, that was used in association with the event. If more than one type of anesthesia was used in association with the event (e.g., local/topical anesthesia and general anesthesia), either simultaneously or sequentially, select each type of anesthesia and/or sedation used from the above answer values.
References:	No specific reference at this time.
Collected in Module(s):	Anesthesia
Comments:	None defined at this time.
Description of Change:	N/A
Rationale for Change:	N/A
Start Date:	5/18/2017
Update Date:	N/A

Data Element Name:	**Characterization of anesthesia event**
Data Element ISO Name:	Event_Anesthesia-Characteristic,CD
Data Element ID:	DE522
Definition:	Determination of what best characterizes the anesthesia event.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Which of the following best characterizes the anesthesia event?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A2256	Difficulty managing airway	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2235	Dental injury	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2238	Ocular injury	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2241	Peripheral nerve injury	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2244	Awareness (during general anesthesia)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2247	Malignant hyperthermia	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2248	Physiologic complication not present prior to anesthesia	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A66	Other: Please specify	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	5 (2000 for free text associated with "Other: Please specify" response.)
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	If the event involved more than one of the listed responses, select the response that best characterizes the anesthesia event. Select "Other: Please specify" if the complication of anesthesia is not listed in the above answer values.
References:	No specific reference at this time.
Collected in Module(s):	Anesthesia
Comments:	None defined at this time.
Description of Change:	The "Surgery or Anesthesia" module, in Common Formats Hospital Version 1.2, has been separated into two modules, "Surgery" and "Anesthesia" in the Common Formats Hospital Version 2.0. Removed: -A2250 "Problem with anesthetic, medical gas, medication, or other substance" -A2253 "Problem with device used in the delivery of anesthesia" Added: -A2248 "Physiologic complication not present prior to anesthesia" Changed: -Question text from "If the event involved anesthesia, which of the following best characterizes the event?" to "Which of the following best characterizes the anesthesia event?" -A2244 from "Awareness (during anesthesia)" to "Awareness (during general anesthesia)" -Guide for Use text from "If the event involved more than one of the listed responses, select the response that best characterizes the event. If the event is best characterized by something that is not listed, select "Other: Please specify" and enter your characterization." to "If the event involved more than one of the listed responses, select the response that best characterizes the event. Select "Other: Please specify" if the complication of anesthesia is not listed in the above answer values."

Rationale for Change:	Question text clarification, Answer value clarification, and Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Difficulties managing airway**
Data Element ISO Name:	Managing airway-Difficulties,CD
Data Element ID:	DE525
Definition:	Determination of the best characterization of the anesthesia adverse outcome of difficulty managing the airway.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Which of the following best characterizes the difficulty managing the airway?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A2262	Difficulty during tracheal intubation	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2265	Difficulty maintaining airway during procedure	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2268	Esophageal intubation	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2271	Re-intubation, following extubation, in the operating or recovery room	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A66	Other: Please specify	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	5 (2000 for free text associated with "Other: Please specify" response.)
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	No further information provided.
References:	No specific reference at this time.
Collected in Module(s):	Anesthesia
Comments:	None defined at this time.
Description of Change:	The "Surgery or Anesthesia" module, in Common Formats Hospital Version 1.2, has been separated into two modules, "Surgery" and "Anesthesia" in the Common Formats Hospital Version 2.0. Changed: -Data Element Name from "Characteristics of airway management problem" to "Difficulties managing airway" -Data Element ISO Name from "Problem_Airway management-Characteristics,CD" to "Managing airway-Difficulties,CD" -Definition from "Determination of the best characterization of the anesthesia adverse outcome of difficulty managing airway." to "Determination of the best characterization of the anesthesia adverse outcome of difficulty managing the airway." -Question text from "Which of the following best characterizes the airway management problem?" to "Which of the following best characterizes the difficulty managing the airway?"
Rationale for Change:	Data Element Name clarification, Data Element ISO Name clarification, Definition text clarification, and Question text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Blood or Blood Product

Data Element Name:	**Type of blood or blood product**
Data Element ISO Name:	Event_Blood product-Type,CD
Data Element ID:	DE114
Definition:	Determination of what type of blood or blood product was involved in the event or unsafe condition.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What type of blood or blood product was involved in the event or unsafe condition?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A534	Red blood cells	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A537	Platelets	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A540	Plasma	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A543	Cryoprecipitate	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A544	Hematopoietic stem cells	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A531	Whole blood	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A549	Lymphocytes	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A546	Granulocytes	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A66	Other: Please specify	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	4 (2000 for free text associated with "Other: Please specify" response.)
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	If more than one type of blood or blood product was administered to the patient and you are unable to assign involvement in the event to a single product type, select "Other: Please specify" and describe all potentially-involved blood product types, excluding plasma derivatives, in the space provided.
References:	No specific reference at this time.
Collected in Module(s):	Blood or Blood Product
Comments:	None defined at this time.
Description of Change:	Removed: -A552 "Albumin" -A555 "Factors (e.g., VII, VIII, IX, AT III)" -A558 "IV immunoglobulin" -A561 "RhIg" Added: -A544 "Hematopoietic stem cells" Changed: -Data Element name from "Type of blood product" to "Type of blood or blood product" -Definition text from "Determination of what type of blood product was involved in the event." to "Determination of what type of blood or blood product was involved in the event or unsafe condition." -Question text from "What type of blood product was involved in the event or unsafe condition?" to "What type of blood or blood product was involved in the event or unsafe condition?" -Guide for Use text from "If more than one type of blood product was administered to the patient and you are unable to assign involvement in the event to a single product type, select 'Other' and specify all potentially-involved product types in the space provided." to "If more than one type of blood or blood product was administered to the patient and you are unable to assign involvement in the event to a single

	product type, select "Other: Please specify" and describe all potentially-involved blood product types, excluding plasma derivatives, in the space provided."
Rationale for Change:	Data Element Name, Definition text clarification, Question text clarification, Answer value clarification, and Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Incorrect action in blood or blood product processing or administration**
Data Element ISO Name:	Processing or administration_Blood product-Incorrect action,CD
Data Element ID:	DE123
Definition:	Determination of the incorrect action involved in processing or administering the blood product.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What incorrect action was involved in processing or administering the blood or blood product?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A585	Incorrect patient	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A588	Incorrect ABO/Rh type	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A600	Incorrect volume (e.g., number of milliliters or units)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A603	Incorrect IV fluid (i.e., administered product with incorrect IV fluid)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A606	Incorrect timing (e.g., delay in administration)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A609	Incorrect rate	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A591	Incorrect product (e.g., product not irradiated when it was ordered or red blood cells given when plasma was ordered)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A594	Incorrect sequence of administration of products	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A597	Use of expired or unacceptably stored product(s)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A66	Other: Please specify	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	4 (2000 for free text associated with "Other: Please specify" response.)
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only if you are reporting an incident or near miss. Blood or blood products do not include plasma derivatives. Plasma derivatives are biologics and are included under Medications. Select "Other: Please specify" if you are reporting a type of incorrect action that is not listed. Select "Unknown" if the incorrect action is unknown.
References:	No specific reference at this time.
Collected in Module(s):	Blood or Blood Product
Comments:	None defined at this time.
Description of Change:	Added: -Guide for Use text "Blood or blood products do not include plasma derivatives. Plasma derivatives are biologics and are included under Medications."

	-Guide for Use text "Select "Other: Please specify" if you are reporting a type of incorrect action that is not listed." -Guide for Use text "Select "Unknown" if the incorrect action is unknown." Changed: -Data Element Name from "Incorrect action in blood or blood product administration" to "Incorrect action in blood or blood product processing or administration" -Data Element ISO Name from "Administration_Blood product-Incorrect action,CD" to "Processing or administration_Blood product-Incorrect action,CD" -Definition from "Determination of the incorrect action involved in administering the blood product." to "Determination of the incorrect action involved in processing or administering the blood product." -Question text from "What incorrect action was involved in administering the blood or blood product?" to "What incorrect action was involved in processing or administering the blood or blood product?" -Guide for Use text from "No further information provided" to "Answer this question only if you are reporting an incident or near miss." -A600 from "Incorrect volume (e.g., number of units or milliliters)" to "Incorrect volume (e.g., number of milliliters or units)" -A591 from "Incorrect product (e.g., giving heterologous blood product when autologous blood product should have been given)" to "Incorrect product (e.g., product not irradiated when it was ordered or red blood cells given when plasma was ordered)" -A597 from "Incorrect use of expired or unacceptably stored products" to "Use of expired or unacceptably stored product(s)"
Rationale for Change:	Data Element Name clarification, Data Element ISO Name clarification, Definition text clarification, Question text clarification, Guide for Use text clarification, and Answer value clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Device or Medical/Surgical Supply

Data Element Name:	**Type of device or supply**
Data Element ISO Name:	Event_Device-Type,CD
Data Element ID:	DE141
Definition:	The type of device or supply involved in the event or unsafe condition.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What type of device or supply was involved in the event or unsafe condition?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A741	Implantable device (i.e., device intended to be inserted into, and remain permanently in, tissue) (e.g., joint replacement, implantable pacemaker)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A744	Medical equipment (e.g., walker, hearing aid)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A747	Medical/surgical supply, including disposable product (e.g., incontinence supply)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	4
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	An "Implantable Device" is a device that is intended to be inserted into, and remain permanently in, tissue. "Non-Implantable Devices" are types of "Medical Equipment."
References:	No specific reference at this time.
Collected in Module(s):	Device or Medical/Surgical Supply
Comments:	None defined at this time.
Description of Change:	Health Information Technology (HIT) is not included in the Device or Medical/Surgical Supply module. HIT is included in the Generic module as a "Contributing Factor." Removed: -A2310 "HIT device" -Guide for Use text "An 'HIT device' includes hardware or software that is used to electronically create, maintain, analyze, store, or receive information to aid in the diagnosis, cure, mitigation, treatment, or prevention of disease and that is not an integral part of (1) an implantable device or (2) an item of medical equipment." Changed: -Data Element Name from "Type of device" to "Type of device or supply" -Definition text from "The type of device involved in the event." to "The type of device or supply involved in the event or unsafe condition." -Question text from "What type of device was involved in the event or unsafe condition?" to "What type of device or supply was involved in the event or unsafe condition?" -A741 from "Implantable device (i.e., device intended to be inserted into, and remain permanently in, tissue)" to "Implantable device (i.e., device intended to be inserted into, and remain permanently in, tissue) (e.g., joint replacement, implantable pacemaker)"
Rationale for Change:	Data Element Name clarification, Definition text clarification, Question text clarification, Answer value clarification, and Guide for Use text clarification.

Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Implantable device removal**
Data Element ISO Name:	Device_Implantable-Removal,CD
Data Element ID:	DE147
Definition:	Determination if the event resulted in the device being removed.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Did the event result in the device being removed?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A15	Yes	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A18	No	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	3
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only if the device was in place within the patient's tissue at the time of the event. Select "Yes" if the event resulted in the device being removed. Select "No" if the event did not result in the device being removed. Select "Unknown" if you are unsure that the event resulted in the device being removed.
References:	No specific reference at this time.
Collected in Module(s):	Device or Medical/Surgical Supply
Comments:	None defined at this time.
Description of Change:	Added: -Guide for Use text "Select "Yes" if the event resulted in the device being removed. Select "No" if the event did not result in the device being removed. Select "Unknown" if you are unsure that the event resulted in the device being removed." Changed: -Definition text from "Determination if the event resulted in the implantable device being removed." to "Determination if the event resulted in the device being removed."
Rationale for Change:	Definition text clarification and Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Device event description**
Data Element ISO Name:	Event_Device-Description,CD
Data Element ID:	DE156
Definition:	Determination of the best description of the event or unsafe condition involving the device.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Which of the following best describes the event or unsafe condition involving the device?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A776	Device defect or failure	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A777	Use error	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A780	Combination or interaction of device defect or failure and use error	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	4
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	No further information provided.
References:	No specific reference at this time.
Collected in Module(s):	Device or Medical/Surgical Supply
Comments:	None defined at this time.
Description of Change:	Removed: -A753 "Device defect or failure, including HIT" Added: -A776 "Device defect or failure" Changed: -Definition text from "Determination of the best description of the event or unsafe condition." to "Determination of the best description of the event or unsafe condition involving the device." -Question text from "Which of the following best describes the event or unsafe condition?" to "Which of the following best describes the event or unsafe condition involving the device?"
Rationale for Change:	Definition text clarification, Question text clarification, and Answer value clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Reuse of single-use device**
Data Element ISO Name:	Event_Device-Single use,CD
Data Element ID:	DE165
Definition:	Event involving a device intended for single use.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Was a device intended for a single use reused in the event or unsafe condition?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A15	Yes	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A18	No	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	3
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	If the device involved was a device intended for single use, select "Yes" even if the device had not yet been re-used.
References:	No specific reference at this time.
Collected in Module(s):	Device or Medical/Surgical Supply
Comments:	None defined at this time.
Description of Change:	Changed: -Definition text from "Event involved device intended for single use." to "Event involving a device intended for single use."
Rationale for Change:	Definition text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Unique Device Identifier**
Data Element ISO Name:	Device-Unique Device Identifier (UDI),ED
Data Element ID:	DE189
Definition:	The Unique Device Identifier (UDI).
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What is the Unique Device Identifier (UDI)?
Value Domain:	N/A
Maximum Length:	2000
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Encapsulated Data (ED)
Guide for Use:	Enter the Unique Device Identifier (UDI), when available. This information will not be forwarded to the Network of Patient Safety Databases (NPSD).
References:	http://www.fda.gov/medicaldevices/deviceregulationandguidance/uniquedeviceidentification/default.htm
Collected in Module(s):	Device or Medical/Surgical Supply
Comments:	None defined at this time.
Description of Change:	Changed: -Guide for Use text from "Enter the UDI when available. This information will not be forwarded to the Network of Patient Safety Databases (NPSD)." to "Enter the Unique Device Identifier (UDI), when available. This information will not be forwarded to the Network of Patient Safety Databases (NPSD).
Rationale for Change:	Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Implantable device time**
Data Element ISO Name:	Device_Implantable,CD
Data Element ID:	DE2009
Definition:	Determination of the timing of the event relative to the device being implanted.
Version:	Hospital Version 2.0
Question:	When did the event involving the implantation of the device occur?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A3000	Event prior to time of implantation (e.g., near miss)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A3003	Event at time of implantation	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A3006	Event following implantation	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	5
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Select A3000 "Event prior to time of implantation (e.g., near miss)" if the event was a near miss. Select A3003 "Event at time of implantation" if the event occurred at the time of device implantation. Select A3006 "Event following implantation" if the event occurred after the time of implantation.
References:	No specific reference at this time.
Collected in Module(s):	Device or Medical/Surgical Supply
Comments:	None defined at this time.
Description of Change:	N/A
Rationale for Change:	N/A
Start Date:	5/18/2017
Update Date:	N/A

Data Element Name:	**Event involved medication or other substance**
Data Element ISO Name:	Event_Medication/Substance,CD
Data Element ID:	DE531
Definition:	Determination if the event or unsafe condition involved a medication or other substance.
Version:	Hospital Version 1.2; Hospital Version 2.0
Question:	Did the event or unsafe condition involve a medication or other substance?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A15	Yes	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A18	No	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	3
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	If the event or unsafe condition being reported involved a medication or other substance (e.g., a device delivered an incorrect dose of medication because of a malfunction), please also complete the "Medication or Other Substance" module.
References:	No specific reference at this time.
Collected in Module(s):	Device or Medical/Surgical Supply
Comments:	None defined at this time.
Description of Change:	Changed: -Guide for Use text from "If the event or unsafe condition being reported involved a medication or other substance, e.g., a device delivered an incorrect dose of medication because of a malfunction, please also complete the "Medication or Other Substance" form." to "If the event or unsafe condition being reported involved a medication or other substance (e.g., a device delivered an incorrect dose of medication because of a malfunction), please also complete the "Medication or Other Substance" module."
Rationale for Change:	Guide for Use text clarification.
Start Date:	4/3/2012
Update Date:	5/18/2017

Fall

Data Element Name:	**Unassisted or assisted fall**
Data Element ISO Name:	Fall-Type,CD
Data Element ID:	DE192
Definition:	Determination if the fall was unassisted or assisted.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Was the fall unassisted or assisted?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A867	Unassisted	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A870	Assisted (e.g., when patient begins to fall and is assisted to the ground by another person)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	4
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	An assisted fall occurs when the patient begins to fall, is assisted by another person, but nevertheless reaches the ground or other unintended surface. An assisted fall is an incident and not a near miss, since the patient is not prevented from reaching the ground or unintended surface.
References:	No specific reference at this time.
Collected in Module(s):	Fall
Comments:	None defined at this time.
Description of Change:	Changed: -A870 from "Assisted" to "Assisted (e.g., when patient begins to fall and is assisted to the ground by another person)"
Rationale for Change:	Answer value clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Type of injury as result of fall**
Data Element ISO Name:	Injury_Fall-Type,CD
Data Element ID:	DE204
Definition:	Determination of the type of injury sustained by the patient as a result of the fall.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What was the most severe type of injury sustained by the patient as a result of the fall?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A906	Intracranial injury	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A903	Fracture	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A900	Dislocation	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A909	Laceration requiring sutures	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A905	Skin tear, avulsion, hematoma or significant bruising	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A66	Other: Please specify	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A910	No injury	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	4 (2000 for free text associated with "Other: Please specify" response.)
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	If the patient sustained more than one type of injury as a result of the fall, select the injury which in your judgment caused the greatest harm to the patient. You may wish to refer to AHRQ's Harm Scale in arriving at your determination. A determination of "No harm" on the AHRQ Harm Scale will be used to indicate there was "No injury" as a result of the fall. Select "Other: Please specify" if the patient injury is not included in the Answer value set above.
References:	No specific reference at this time.
Collected in Module(s):	Fall
Comments:	None defined at this time.
Description of Change:	Added: -A910 "No injury" Changed: -Question text from "What type of injury was sustained?" to "What was the most severe type of injury sustained by the patient as a result of the fall?" -Guide for Use text from "If the patient sustained more than one type of injury as a result of the fall, select the injury which in your judgment caused the greatest harm to the patient. You may wish to refer to AHRQ's Harm Scale in arriving at your determination." to "If the patient sustained more than one type of injury as a result of the fall, select the injury which in your judgment caused the greatest harm to the patient. You may wish to refer to AHRQ's Harm Scale in arriving at your determination. A determination of "No harm" on the AHRQ Harm Scale will be used to indicate there was "No injury" as a result of the fall. Select "Other: Please specify" if the patient injury is not included in the Answer value set above."
Rationale for Change:	Question text clarification, Answer value clarification, and Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Risk assessment prior to fall**
Data Element ISO Name:	Fall_Risk assessment-Documentation_Prior to Fall,CD
Data Element ID:	DE210
Definition:	Determination if the patient was assessed to be a risk for a fall.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Prior to the fall, was a fall risk assessment documented?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A15	Yes	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A18	No	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	3
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Select "Yes" if there is any fall risk assessment documented in the patient's medical record prior to the fall. Any type of fall risk assessment will qualify; no particular type of fall risk assessment is required.
References:	No specific reference at this time.
Collected in Module(s):	Fall
Comments:	None defined at this time.
Description of Change:	N/A
Rationale for Change:	N/A
Start Date:	3/31/2010
Update Date:	4/3/2012

Data Element Name:	**At risk for fall**
Data Element ISO Name:	Fall-Risk_Patient,CD
Data Element ID:	DE213
Definition:	Determination if the patient was at risk for a fall.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Was the patient determined to be at increased risk for a fall?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A15	Yes	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A18	No	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	3
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Enter the determination from the risk assessment made prior to the fall. Select "Yes" if the patient was at increased risk for fall. Select "No" if the patient was not at increased risk for fall. Select "Unknown" if the patient risk for fall is unknown.
References:	No specific reference at this time.
Collected in Module(s):	Fall
Comments:	None defined at this time.
Description of Change:	Changed: -Guide for Use text from "Enter the determination from the risk assessment made prior to the fall." to "Enter the determination from the risk assessment made prior to the fall. Select "Yes" if the patient was at increased risk for fall. Select "No" if the patient was not at increased risk for fall. Select "Unknown" if the patient risk for fall is unknown."
Rationale for Change:	Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Generic

Data Element Name:	**Contributing factor(s) for event**
Data Element ISO Name:	Event-Contributing factor(s),CD
Data Element ID:	DE105
Definition:	Determination if any contributing factor(s) to the event are known.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What factor(s) contributed to the event?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A3009	Communication, other than at the time of handover/handoff	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A3012	Handover/handoff	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A3015	Data issues (e.g., availability, accuracy)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A3018	Environment (e.g., culture of safety, physical surroundings)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A3021	Human factors (e.g., fatigue, stress, inattention, cognitive factors)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A3024	Policies and procedures, including clinical protocols (e.g., absence, adequacy, clarity)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A3027	Staff qualifications (e.g., competence, training)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A3030	Supervision/support (e.g., clinical, managerial)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A3033	Health Information Technology (HIT)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A66	Other: Please specify	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	5 (2000 for free text associated with "Other: Please specify" response.)
Multiple Choice:	Yes
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only if you are reporting an incident or near miss.
References:	No specific reference at this time.
Collected in Module(s):	Generic
Comments:	None defined at this time.
Description of Change:	Removed: -A384 "Environment: Culture of safety, management" -A387 "Environment: Physical surroundings (e.g., lighting, noise)" -A390 "Staff qualifications: Competence (e.g., qualifications, experience)" -A393 "Staff qualifications: Training" -A396 "Supervision/support: Clinical supervision" -A399 "Supervision/support: Managerial supervision"

	-A402 "Policies and procedures, includes clinical protocols: Presence of policies" -A405 "Policies and procedures, includes clinical protocols: Clarity of policies" -A420 "Data: Availability" -A423 "Data: Accuracy" -A424 "Data: Legibility" -A426 "Communication: Supervisor to staff" -A429 "Communication: Among staff or team members" -A432 "Communication: Staff to patient (or family)" -A435 "Human Factors: Fatigue" -A438 "Human Factors: Stress" -A441 "Human Factors: Inattention" -A444 "Human Factors: Cognitive factors" -A447 "Human Factors: Health issues" Added: -A3009 "Communication, other than at the time of handover/handoff" -A3012 "Handover/handoff" -A3015 "Data issues (e.g., availability, accuracy)" -A3018 "Environment (e.g., culture of safety, physical surroundings)" -A3021 "Human factors (e.g., fatigue, stress, inattention, cognitive factors)" -A3024 "Policies and procedures, including clinical protocols (e.g., absence, adequacy, clarity)" -A3027 "Staff qualifications (e.g., competence, training)" -A3030 "Supervision/support (e.g., clinical, managerial)" -A3033 "Health Information Technology (HIT)"
Rationale for Change:	Answer value clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Patient Sex**
Data Element ISO Name:	Patient Sex,CD
Data Element ID:	DE1106
Definition:	The patient's biological sex.
Version:	Hospital Version 2.0
Question:	What is the patient's biological sex?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
M	Male	2.16.840.1.113883.5.1	HL7 Administrative Gender
F	Female	2.16.840.1.113883.5.1	HL7 Administrative Gender
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	3
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only if you are reporting an incident.
References:	No specific reference at this time.
Collected in Module(s):	Generic
Comments:	None defined at this time.
Description of Change:	N/A
Rationale for Change:	N/A
Start Date:	12/16/2016
Update Date:	N/A

Data Element Name:	**Linked event ID**
Data Element ISO Name:	Linked event-Event ID,ED
Data Element ID:	DE112
Definition:	Provides ability to link a Common Formats patient safety event or unsafe condition report to another Common Formats Patient Safety event or unsafe condition report.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What is the linked event ID?
Value Domain:	N/A
Maximum Length:	16
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Encapsulated Data (ED)
Guide for Use:	If a Common Formats patient safety event or unsafe condition report is linked to another Common Formats patient safety event or unsafe condition report, enter the Event ID of the linked report for this data element to link the two reports. If a Common Formats patient safety event or unsafe condition report is linked to more than one report, provide this data element for each additional linked report.
References:	No specific reference at this time.
Collected in Module(s):	Generic
Comments:	None defined at this time.
Description of Change:	Changed: -Question from "Linked event ID" to "What is the linked event ID?" -Guide for Use text from "If a Common Formats patient safety event or unsafe condition report is linked to another Common Formats patient safety event or unsafe condition report, enter the Event ID of the linked report for this data element to link the two reports. If a Common Formats patient safety event or unsafe condition report is linked to more than one report, provide this data element for each additional linked report. This data element is for electronic implementation only. It is not on the Common Formats paper form." to "If a Common Formats patient safety event or unsafe condition report is linked to another Common Formats patient safety event or unsafe condition report, enter the Event ID of the linked report for this data element to link the two reports. If a Common Formats patient safety event or unsafe condition report is linked to more than one report, provide this data element for each additional linked report."
Rationale for Change:	Question text clarification and Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Reason for linking**
Data Element ISO Name:	Linking-Reason,CD
Data Element ID:	DE113
Definition:	Provides the reason for linking Common Formats patient safety event or unsafe condition reports.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What is the reason for linking?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A2273	Linking more than one patient involved in an event	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2274	Linking more than one related event	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A66	Other: Please specify	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	5 (2000 for free text associated with "Other: Please specify" response.)
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	If a Common Formats patient safety event or unsafe condition report is linked to another Common Formats patient safety event or unsafe condition report, select the applicable reason for linking of the reports. If the reason for linking is not one of the answer values provided with this data element, select "Other: Please specify" and describe the reason for linking. If a Common Formats patient safety event or unsafe condition report is linked to more than one report, provide this data element for each additional linked report.
References:	No specific reference at this time.
Collected in Module(s):	Generic
Comments:	None defined at this time.
Description of Change:	Changed: -Question from "Reason for linking" to "What is the reason for linking?" -Guide for Use text from "If a Common Formats patient safety event or unsafe condition report is linked to another Common Formats patient safety event or unsafe condition report, select the applicable reason for linking of the reports. If the reason for linking is not one of the answer values provided with this data element, select "Other" and specify the reason for linking. If a Common Formats patient safety event or unsafe condition report is linked to more than one report, provide this data element for each additional linked report. This data element is for electronic implementation only. It is not on the Common Formats paper form." to "If a Common Formats patient safety event or unsafe condition report is linked to another Common Formats patient safety event or unsafe condition report, select the applicable reason for linking of the reports. If the reason for linking is not one of the answer values provided with this data element, select "Other: Please specify" and describe the reason for linking. If a Common Formats patient safety event or unsafe condition report is linked to more than one report, provide this data element for each additional linked report."
Rationale for Change:	Question text clarification and Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Description of event or unsafe condition**
Data Element ISO Name:	Event or unsafe condition-Description,ED
Data Element ID:	DE15
Definition:	Description of the event that occurred or unsafe condition that exists.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Briefly describe the event that occurred or unsafe condition.
Value Domain:	N/A
Maximum Length:	2000
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Encapsulated Data (ED)
Guide for Use:	Describe the specifics of the incident, near miss or unsafe condition in your own words, as best you know them. This information is not transmitted to the Network of Patient Safety Databases (NPSD).
References:	No specific reference at this time.
Collected in Module(s):	Generic
Comments:	None defined at this time.
Description of Change:	Changed: -Guide for Use text from "Describe the specifics of the incident, near miss or unsafe condition in your own words, as best you know them at this time. There will be opportunity to supplement this information as more details become known. This information is not transmitted to the Network of Patient Safety Databases (NPSD)." to "Describe the specifics of the incident, near miss or unsafe condition in your own words, as best you know them. This information is not transmitted to the Network of Patient Safety Databases (NPSD)."
Rationale for Change:	Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Category(s) associated with event or unsafe condition**
Data Element ISO Name:	Event or unsafe condition-Category,CD
Data Element ID:	DE21
Definition:	Documentation of the category of event that was being reported to include an incident, near miss or unsafe condition.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Which of the following categories are associated with the event or unsafe condition?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A41	Anesthesia	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A42	Blood or Blood Product	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A45	Device or Medical/Surgical Supply	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A48	Fall	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A51	Healthcare-associated Infection	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A54	Medication or Other Substance	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A57	Perinatal	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A60	Pressure Injury	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A61	Surgery, includes invasive procedure	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A64	Venous Thromboembolism	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A66	Other: Please specify	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	3 (2000 for free text associated with "Other: Please specify" response.)
Multiple Choice:	Yes
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Common Formats have been defined for nine specified categories of patient safety concerns. For the patient safety concern you are reporting, please select all of the categories in the list that apply to that concern, and, for each category selected, except "Healthcare-associated Infection" and "Other: Please specify", complete the corresponding category-specific module. Select "Anesthesia" if the concern you are reporting involved the administration of anesthesia or sedation, regardless of whether a surgical procedure was involved, and if the concern was an incident or a near miss. Select "Blood or Blood Product" if the concern you are reporting involved the processing and/or administration of blood or a blood product, and if the concern was an incident, a near miss, or an unsafe condition. Select "Device or Medical/Surgical Supply" if the concern you are reporting involved a device failure or incorrect use of a device, and if the concern was an incident, a near miss, or an unsafe condition. A device includes an implant, medical equipment, or a medical/surgical supply (including a disposable product). Select "Fall" if the concern you are reporting involved a sudden, unintended, descent of a patient's body to the ground or other unintended surface, and if the concern was an incident. Select "Healthcare-associated Infection" if the concern you are reporting was a healthcare-associated infection, but you do not need to report any additional information to the PSOPPC.

	Select "Medication or Other Substance" if the concern you are reporting involved a substance such as a medication, vaccine, or medical gas, and if the concern was an incident, a near miss, or an unsafe condition. Select "Perinatal" if the concern you are reporting involved an adverse outcome occurring during the perinatal period to the mother, fetus(es), or neonate(s) and the concern involved the birthing process or an intrauterine procedure that occurred prior to the onset of labor, and if the concern was an incident. The perinatal period extends from the 20th week of gestation through 4 weeks (28 days) post-partum. The neonatal period extends from birth until the end of the perinatal period. Select "Pressure Injury" if the concern you are reporting involved a pressure injury or deep tissue injury that was not present on admission or that worsened during the patient's stay, and if the concern was an incident. Select "Surgery" if the concern you are reporting involved a surgical or other invasive procedure (e.g., colonoscopy), and if the concern was an incident or a near miss. Select "Venous Thromboembolism" if the concern you are reporting involved one or both of the following: 1) a deep vein thrombosis (DVT) or 2) a pulmonary embolism (PE), and if the concern was an incident. Select "Other: Please specify" if the concern you are reporting does not belong to any of the listed categories, and if the concern in an incident, a near miss, or an unsafe condition. If so, please describe the event in a few words.
References:	No specific reference at this time.
Collected in Module(s):	Generic
Comments:	None defined at this time.
Description of Change:	“Surgery” and “Anesthesia” have been divided into separate modules. Events involving Health Information Technology (HIT) are no longer reported in the “Device or Medical/Surgical Supply” module, but the involvement of HIT can be reported as a contributing factor for any event as part of the “Generic” flow. While the occurrence of a “Healthcare-associated Infection” can be noted, it is no longer reported via a separate module. Lastly, the “Pressure Ulcer” module has been renamed to “Pressure Injury” to align with current National Pressure Ulcer Advisory Panel (NPUAP) guidelines. Removed: -A44 “Device or Medical/Surgical Supply, include Health Information Technology (HIT)” -A63 “Surgery or Anesthesia (including invasive procedure)” Added: -A41 “Anesthesia” -A45 “Device or Medical/Surgical Supply” -A61 “Surgery, includes invasive procedure” Changed: -A60 “Pressure Ulcer” to “Pressure Injury” -Guide for Use text to indicate the correct number of categories or modules of patient safety concerns, to specify the concern type for each module (i.e., incident, near miss, or unsafe condition), and to remove redundant guidance regarding the concern type associated with each module.
Rationale for Change:	Answer value clarification and Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Report type**
Data Element ISO Name:	Report-Type,CD
Data Element ID:	DE3
Definition:	The patient safety event or unsafe condition that is being reported.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What is being reported?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A3	Incident: A patient safety event that reached the patient, whether or not the patient was harmed.	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A6	Near Miss: A patient safety event that did not reach the patient.	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A9	Unsafe Condition: Any circumstance that increases the probability of a patient safety event.	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	2
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	There are three mutually exclusive types of patient safety concerns. An "incident" is a patient safety concern that reaches the patient, whether or not the patient suffers harm from the incident. A "near miss" is a patient safety concern that does not reach the patient. Incidents and near misses are also referred to as patient safety events. An "unsafe condition", the third type of patient safety concern, is a circumstance that increases the probability that a patient safety event will occur. An "unsafe condition" is not referred to as a patient safety event.
References:	No specific reference at this time.
Collected in Module(s):	Generic
Comments:	None defined at this time.
Description of Change:	Changed: -Guide for Use text from "There are three mutually exclusive types of patient safety concerns. An incident is a patient safety concern that reaches the patient, whether or not the patient suffers harm from the incident. A near miss is a patient safety concern that does not reach the patient. Incidents and near misses are also referred to as patient safety events. An unsafe condition, the third type of patient safety concern, is a circumstance that increases the probability that a patient safety event will occur; an unsafe condition is not referred to as a patient safety event." to "There are three mutually exclusive types of patient safety concerns. An incident is a patient safety concern that reaches the patient, whether or not the patient suffers harm from the incident. A near miss is a patient safety concern that does not reach the patient. Incidents and near misses are also referred to as patient safety events. An unsafe condition, the third type of patient safety concern, is a circumstance that increases the probability that a patient safety event will occur. An unsafe condition is not referred to as a patient safety event."
Rationale for Change:	Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Initial report date**
Data Element ISO Name:	Report_Initial-Date,TS
Data Element ID:	DE30
Definition:	Documentation of the date the Common Formats patient safety module was completed.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What is the date the Common Formats patient safety module was completed?
Value Domain:	N/A
Maximum Length:	24
Multiple Choice:	No
Format:	Refer to Common Formats Resources Workbook (Validation Tab).
Data Type:	Date/Time
HL7 Data Type:	Point in Time (TS)
Guide for Use:	Enter the date the Common Formats patient safety module was completed.
References:	No specific reference at this time.
Collected in Module(s):	Generic
Comments:	None defined at this time.
Description of Change:	Changed: -Definition from "Documentation of the date the Healthcare Event Report Form was completed" to "Documentation of the date the Common Formats patient safety module was completed." -Question from "Initial Report Date:" to "What is the date the Common Formats patient safety module was completed?" -Guide for Use text from "Enter the date the Healthcare Event Report Form (HERF) was completed by the reporter." to "Enter the date the Common Formats patient safety module was completed."
Rationale for Change:	Definition text clarification, Question text clarification, and Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Neonate date of birth**
Data Element ISO Name:	Neonate_DOB,TS
Data Element ID:	DE37
Definition:	Documentation of the month, day, and year the neonate was born.
Version:	Hospital Version 1.2; Hospital Version 2.0
Question:	What is the neonate's date of birth?
Value Domain:	N/A
Maximum Length:	24
Multiple Choice:	No
Format:	N/A
Data Type:	Date/Time
HL7 Data Type:	Point in Time (TS)
Guide for Use:	Answer this question only if you are reporting a perinatal incident. Enter the neonate’s date of birth. This information is not transmitted to the Network of Patient Safety Databases (NPSD).
References:	No specific reference at this time.
Collected in Module(s):	Generic
Comments:	None defined at this time.
Description of Change:	Changed: -Question from "Neonate's Date of Birth:" to "What is the neonate's date of birth?" -Guide for Use text from "Answer this question only if you are reporting an incident." to "Answer this question only if you are reporting a perinatal incident."
Rationale for Change:	Question text clarification and Guide of Use text clarification.
Start Date:	4/3/2012
Update Date:	5/18/2017

Data Element Name:	**Patient age range**
Data Element ISO Name:	Patient-Age range,CD
Data Element ID:	DE45
Definition:	The patient's age.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	At the time of the incident, what was the patient's age?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A106	Neonate (less than 30 days)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A107	Infant (greater than or equal to 30 days but less than 1 year)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A109	Early childhood (greater than or equal to 1 year but less than 5 years)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A110	Late childhood (greater than or equal to 5 years but less than 13 years)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A111	Adolescent (13-17 years)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A114	Adult (18-64 years)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A117	Mature adult (65-74 years)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A120	Older adult (75-84 years)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A123	Aged adult (85+ years)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	4
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only if you are reporting an incident.
References:	No specific reference at this time.
Collected in Module(s):	Generic
Comments:	None defined at this time.
Description of Change:	Removed: -A102 "Neonate (0-28 days)" -A105 "Infant (greater than 28 days but less than 1 year)" -A108 "Child (1-12 years)" Added: -A106 "Neonate (less than 30 days)" -A107 "Infant (greater than or equal to 30 days but less than 1 year)" -A109 "Early childhood (greater than or equal to 1 year but less than 5 years)" -A110 "Late childhood (greater than or equal to 5 years but less than 13 years)" Changed: -Data Element Name from "Patient age" to "Patient age range." -Data Element ISO Name from "Patient-Age, CD" to "Patient-Age range, CD." -Question text from "At the time of the event, what was the patient's age?" to "At the time of the

	incident, what was the patient's age?"
Rationale for Change:	Data Element Name clarification, Data Element ISO Name clarification, Question text clarification, and Answer value clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Patient date of birth**
Data Element ISO Name:	Patient-DOB,TS
Data Element ID:	DE47
Definition:	Documentation of the month, day, and year the patient was born.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What is the patient's date of birth?
Value Domain:	N/A
Maximum Length:	24
Multiple Choice:	No
Format:	Refer to Common Formats Resources Workbook (Validation Tab).
Data Type:	Date/Time
HL7 Data Type:	Point in Time (TS)
Guide for Use:	Answer this question only if you are reporting an incident. Enter the patient's date of birth. This information is not transmitted to the Network of Patient Safety Databases (NPSD).
References:	No specific reference at this time.
Collected in Module(s):	Generic
Comments:	None defined at this time.
Description of Change:	Changed: -Question from "Patient's Date of Birth:" to "What is the patient's date of birth?"
Rationale for Change:	Question text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Hispanic or Latino ethnicity**
Data Element ISO Name:	Patient-Hispanic or Latino ethnicity,CD
Data Element ID:	DE48
Definition:	Determination if the patient has Hispanic or Latino ethnicity.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Is the patient's ethnicity Hispanic or Latino?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
2135-2	Hispanic or Latino	2.16.840.1.113883.6.238	CDC Race and Ethnicity
2186-5	Not Hispanic or Latino	2.16.840.1.113883.6.238	CDC Race and Ethnicity
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	6
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only if you are reporting an incident. Select "Hispanic or Latino" if the patient was of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture. Select "Not Hispanic or Latino" if the patient was not of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture. Select "Unknown" if the patient's Hispanic or Latino ethnicity was unknown.
References:	No specific reference at this time.
Collected in Module(s):	Generic
Comments:	None defined at this time.
Description of Change:	Changed: -Data Element Name from "Hispanic or Latino descent" to "Hispanic or Latino ethnicity" -Guide for Use text from "Select 'Yes' if the patient was of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture. Select 'No' if the patient was not of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture." to "Select "Hispanic or Latino" if the patient was of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture. Select "Not Hispanic or Latino" if the patient was not of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture. Select "Unknown" if the patient's Hispanic or Latino ethnicity was unknown."
Rationale for Change:	Data Element Name clarification and Guide for Use Text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Patient race**
Data Element ISO Name:	Patient-Race,CD
Data Element ID:	DE51
Definition:	Patient race
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What is the patient's race?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
1002-5	American Indian or Alaska Native	2.16.840.1.113883.6.238	CDC Race and Ethnicity
2028-9	Asian	2.16.840.1.113883.6.238	CDC Race and Ethnicity
2054-5	Black or African American	2.16.840.1.113883.6.238	CDC Race and Ethnicity
2076-8	Native Hawaiian or Other Pacific Islander	2.16.840.1.113883.6.238	CDC Race and Ethnicity
2106-3	White	2.16.840.1.113883.6.238	CDC Race and Ethnicity
A153	More than one race	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	6
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only if you are reporting an incident. Select only one answer. "American Indian or Alaska Native" means a person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. "Asian" means a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. "Black or African American" means a person having origins in any of the black racial groups of Africa. "Native Hawaiian or Other Pacific Islander" means a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. "White" means a person having origins in any of the original peoples of Europe, the Middle East, or North Africa. Select "More than one race" if the patient is of more than one race. Select "Unknown" if the patient's race is unknown.
References:	OMB Standards for Data on Race and Ethnicity: http://www.whitehouse.gov/omb/fedreg_1997standards
Collected in Module(s):	Generic
Comments:	None defined at this time.
Description of Change:	Added: -Guide for Use text "Select "Unknown" if the patient's race is unknown."
Rationale for Change:	Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**HIT system or device related to event**
Data Element ISO Name:	Event_System or device-Characterization,CD
Data Element ID:	DE534
Definition:	Documentation of the type of Health Information Technology (HIT) system or device that contributed to a patient safety event. An HIT system or device includes hardware or software that is used to electronically create, maintain, analyze, store, or receive information to aid in the diagnosis, cure, mitigation, treatment, or prevention of disease and that is not an integral part of (1) an implantable device or (2) an item of medical equipment.
Version:	Hospital Version 1.2; Hospital Version 2.0
Question:	Which of the following best characterizes the type of HIT system or device related to the event?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A2316	Administrative/billing or practice management system (e.g., master patient index, registration/appointment scheduling system, coding/billing system)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2319	Automated dispensing system	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2322	Electronic health record (EHR) or component of EHR (e.g., CPOE system, pharmacy system, e-MAR, clinical documentation system [CDS])	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2325	Human interface device (e.g., keyboard, mouse, touchscreen, speech recognition system, monitor/display, printer)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2328	Laboratory information system (LIS), including microbiology, and pathology systems	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2331	Radiology/diagnostic imaging system, including picture archiving and communication system (PACS)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A66	Other: Please specify	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	5 (2000 for free text associated with "Other: Please specify" response.)
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only if you are reporting an incident or near miss. Select "Other: Please specify" if the HIT system or device is not included in the answer value set above.
References:	No specific reference at this time.
Collected in Module(s):	Generic
Comments:	None defined at this time.
Description of Change:	Health Information Technology (HIT) is included in the Generic module as a "Contributing Factor". HIT is

	not included in the "Device or Medical/Surgical Supply" module. Changed: -Data Element Name from "HIT device related to event or unsafe condition" to "HIT system or device related to event or unsafe condition" -Data Element ISO Name from "Event_Device-Characterization,CD" to "Event_System or device-Characterization,CD" -Definition from "Documentation of the type of HIT device involved." to "Documentation of the type of Health Information Technology (HIT) system or device that contributed to a patient safety event." -Question text from "Which of the following best characterizes the type of HIT device related to the event or unsafe condition?" to "Which of the following best characterizes the type of HIT system or device related to the event?" -A2316 from "Administrative/billing or practice management system" to "Administrative/billing or practice management system (e.g., master patient index, registration/appointment scheduling system, coding/billing system)" -A2322 from "Electronic health record (EHR) or component of EHR" to "Electronic health record (EHR) or component of EHR (e.g., CPOE system, pharmacy system, e-MAR, clinical documentation system [CDS])" -Guide for use text from "No further information provided." to "Answer this question only if you are reporting an incident or near miss. Select "Other: Please specify" if the HIT system or device is not included in the answer value set above."
Rationale for Change:	Data Element Name clarification, Data Element ISO Name clarification, Definition text clarification, Question text clarification, Answer value clarification, and Guide for Use text clarification.
Start Date:	4/3/2012
Update Date:	5/18/2017

Data Element Name:	**Degree of harm**
Data Element ISO Name:	Patient-Harm, CD
Data Element ID:	DE55
Definition:	The degree of harm to the patient after discovery of the incident and any attempts to minimize adverse consequences.
Version:	Hospital Version 1.2; Hospital Version 2.0
Question:	After any intervention to reduce harm, what was the degree of residual harm to the patient from the incident (and subsequent intervention(s))?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A162	Death	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A166	Severe harm: Bodily or psychological injury (including pain or disfigurement) that interferes substantially with functional ability or quality of life.	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A169	Moderate harm: Bodily or psychological injury adversely affecting functional ability or quality of life, but not at the level of severe harm.	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A172	Mild harm: Bodily or psychological injury resulting in minimal symptoms or loss of function, or injury limited to additional treatment, monitoring, and/or increased length of stay.	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A180	No harm: Event reached patient, but no harm was evident.	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	4
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only if you are reporting an incident. The answer choices constitute the first part of AHRQ's Harm Scale. This question relates to the intensity of harm that occurred as a result of the incident and not its duration. If you indicate that harm to the patient occurred, you will be asked about the anticipated duration of this harm in the following question. Select "Death" only if the patient died during the stay when the incident occurred and the death was attributable, in whole or in part, to the incident. Do not make this selection if the patient is alive at the time of this report, no matter how bad the patient's prognosis. Do consider updating this report if the patient, who is alive at the time of this assessment, should die prior to discharge. No further explanation is provided regarding the other categories in the Harm Scale. Your selection among these categories should be based on your present assessment of the patient's future condition attributable

	to the incident, taking the likely effects of treatment into account. If you cannot decide between two categories that you believe both apply, select the one that is higher on the list. Select "Unknown" if the degree of harm is unknown.
References:	No specific reference at this time.
Collected in Module(s):	Generic
Comments:	None defined at this time.
Description of Change:	Added: -Guide for Use text "Select "Unknown" if the degree of harm is unknown." Changed: -Data Element Name from "Extent of harm" to "Degree of harm." -Definition text from "The extent of harm to the patient after discovery of the incident and any attempts to minimize adverse consequences." to "The degree of harm to the patient after discovery of the incident and any attempts to minimize adverse consequences." -Question text from "After any intervention to reduce harm, what was the degree of residual harm to the patient from the incident (and subsequent intervention)?" to "After any intervention to reduce harm, what was the degree of residual harm to the patient from the incident (and subsequent intervention(s))?" -A162 from "Death: Dead at time of assessment" to "Death"
Rationale for Change:	Data Element Name clarification, Definition text clarification, Question text clarification, Guide for Use text clarification, and Answer value clarification.
Start Date:	4/3/2012
Update Date:	5/18/2017

Data Element Name:	**Neonate race**
Data Element ISO Name:	Neonate-Race,CD
Data Element ID:	DE56
Definition:	Neonate race
Version:	Hospital Version 2.0
Question:	What is the neonate's race?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
1002-5	American Indian or Alaska Native	2.16.840.1.113883.6.238	CDC Race and Ethnicity
2028-9	Asian	2.16.840.1.113883.6.238	CDC Race and Ethnicity
2054-5	Black or African American	2.16.840.1.113883.6.238	CDC Race and Ethnicity
2076-8	Native Hawaiian or Other Pacific Islander	2.16.840.1.113883.6.238	CDC Race and Ethnicity
2106-3	White	2.16.840.1.113883.6.238	CDC Race and Ethnicity
A153	More than one race	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	6
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only if you are reporting a perinatal incident. Select only one answer. "American Indian or Alaska Native" means a person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. "Asian" means a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. "Black or African American" means a person having origins in any of the black racial groups of Africa. "Native Hawaiian or Other Pacific Islander" means a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. "White" means a person having origins in any of the original peoples of Europe, the Middle East, or North Africa. Select "More than one race" if the patient is of more than one race. Select "Unknown" if the neonate's race is unknown.
References:	OMB Standards for Data on Race and Ethnicity: http://www.whitehouse.gov/omb/fedreg_1997standards
Collected in Module(s):	Generic
Comments:	None defined at this time.
Description of Change:	N/A
Rationale for Change:	N/A
Start Date:	5/18/2017
Update Date:	N/A

Data Element Name:	**Anticipated harm duration**
Data Element ISO Name:	Harm-Duration_anticipated, CD
Data Element ID:	DE59
Definition:	Determination of the anticipated duration of the harm to the patient.
Version:	Hospital Version 1.2; Hospital Version 2.0
Question:	What is the anticipated duration of the harm to the patient?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A192	Permanent: not expected to revert to approximately normal (i.e., patient's baseline)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A194	Temporary: expected to revert to approximately normal (i.e., patient's baseline)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	4
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only if you are reporting an incident and only if you indicated, in your response to the previous harm question, that harm, other than death, had occurred to the patient as a result of the incident. The answer choices constitute the second part of AHRQ's Harm Scale. This question relates to the duration of harm at the intensity you indicated in the previous Harm Scale question. No further explanation is provided regarding the other categories in the Harm Scale. Your selection among these categories should be based on your present assessment of the patient's future condition attributable to the incident, taking the likely effects of treatment into account. If you cannot decide between two categories that you believe both apply, select the one that is higher on the list.
References:	No specific reference at this time.
Collected in Module(s):	Generic
Comments:	None defined at this time.
Description of Change:	N/A
Rationale for Change:	N/A
Start Date:	4/3/2012
Update Date:	4/24/2013

Data Element Name:	**Neonate sex**
Data Element ISO Name:	Neonate-Sex,CD
Data Element ID:	DE61
Definition:	The neonate's biological sex.
Version:	Hospital Version 2.0
Question:	What is the neonate's biological sex?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
M	Male	2.16.840.1.113883.5.1	HL7 Administrative Gender
F	Female	2.16.840.1.113883.5.1	HL7 Administrative Gender
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	3
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only if you are reporting an incident.
References:	No specific reference at this time.
Collected in Module(s):	Generic
Comments:	None defined at this time.
Description of Change:	N/A
Rationale for Change:	N/A
Start Date:	5/18/2017
Update Date:	N/A

Data Element Name:	**Neonate Hispanic or Latino ethnicity**
Data Element ISO Name:	Neonate-Hispanic or Latino ethnicity, CD
Data Element ID:	DE62
Definition:	Determination if the neonate has Hispanic or Latino ethnicity.
Version:	Hospital Version 2.0
Question:	Is the neonate's ethnicity Hispanic or Latino?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
2135-2	Hispanic or Latino	2.16.840.1.113883.6.238	CDC Race and Ethnicity
2186-5	Not Hispanic or Latino	2.16.840.1.113883.6.238	CDC Race and Ethnicity
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	6
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only if you are reporting a perinatal incident. Select "Hispanic or Latino" if the neonate was of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture. Select "Not Hispanic or Latino" if the neonate was not of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture. Select "Unknown" if the neonate's Hispanic or Latino ethnicity was unknown.
References:	No specific reference at this time.
Collected in Module(s):	Generic
Comments:	None defined at this time.
Description of Change:	N/A
Rationale for Change:	N/A
Start Date:	5/18/2017
Update Date:	N/A

Data Element Name:	**Neonate degree of harm**
Data Element ISO Name:	Neonate-Harm,CD
Data Element ID:	DE64
Definition:	The degree of harm to the neonate after discovery of the incident and any attempts to minimize adverse consequences.
Version:	Hospital Version 2.0
Question:	After any intervention to reduce harm, what was the degree of residual harm to the neonate from the incident (and subsequent intervention(s))?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A162	Death	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A166	Severe harm: Bodily or psychological injury (including pain or disfigurement) that interferes substantially with functional ability or quality of life.	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A169	Moderate harm: Bodily or psychological injury adversely affecting functional ability or quality of life, but not at the level of severe harm.	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A172	Mild harm: Bodily or psychological injury resulting in minimal symptoms or loss of function, or injury limited to additional treatment, monitoring, and/or increased length of stay.	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A180	No harm: Event reached patient, but no harm was evident.	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	4
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only if you are reporting an incident. The answer choices constitute the first part of AHRQ's Harm Scale. This question relates to the intensity of harm that occurred as a result of the incident and not its duration. If you indicate that harm to the neonate occurred, you will be asked about the anticipated duration of this harm in the following question. Select "Death" only if the neonate died during the stay when the incident occurred and the death was attributable, in whole or in part, to the incident. Do not make this selection if the neonate is alive at the time of this report, no matter how bad the neonate's prognosis. Do consider updating this report if the neonate, who is alive at the time of this assessment, should die prior to discharge. No further explanation is provided regarding the other categories in the Harm Scale. Your selection among these categories should be based on your present assessment of the neonate's future condition attributable to the

	incident, taking the likely effects of treatment into account. If you cannot decide between two categories that you believe both apply, select the one that is higher on the list. Select "Unknown" if the degree of harm is unknown.
References:	No specific reference at this time.
Collected in Module(s):	Generic
Comments:	None defined at this time.
Description of Change:	N/A
Rationale for Change:	N/A
Start Date:	5/18/2017
Update Date:	N/A

Data Element Name:	**Neonate anticipated harm duration**
Data Element ISO Name:	Neonate-Harm-Duration_anticipated,CD
Data Element ID:	DE65
Definition:	Determination of the anticipated duration of harm to the neonate.
Version:	Hospital Version 2.0
Question:	What is the anticipated duration of the harm to the neonate?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A192	Permanent: not expected to revert to approximately normal (i.e., patient's baseline)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A194	Temporary: expected to revert to approximately normal (i.e., patient's baseline)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	4
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only if you are reporting an incident and only if you indicated, in your response to the previous harm question, that harm, other than death, had occurred to the neonate as a result of the incident. The answer choices constitute the second part of AHRQ's Harm Scale. This question relates to the duration of harm at the intensity you indicated in the previous Harm Scale question. No further explanation is provided regarding the other categories in the Harm Scale. Your selection among these categories should be based on your present assessment of the neonate's future condition attributable to the incident, taking the likely effects of treatment into account. If you cannot decide between two categories that you believe both apply, select the one that is higher on the list.
References:	No specific reference at this time.
Collected in Module(s):	Generic
Comments:	None defined at this time.
Description of Change:	N/A
Rationale for Change:	N/A
Start Date:	5/18/2017
Update Date:	N/A

Data Element Name:	**Location (area of occurrence) of event or unsafe condition**
Data Element ISO Name:	Event or unsafe condition-Location,CD
Data Element ID:	DE78
Definition:	Determination of where the event or unsafe condition occurred.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Where did the event or unsafe condition occur?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A249	Inpatient general care area (e.g., medical/surgical unit)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A252	Special care area (e.g., ICU, CCU, NICU)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A255	Labor and delivery	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A258	Operating room or procedure area (e.g., cardiac catheter lab, endoscopy area), including PACU or recovery area	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A261	Radiology/imaging department, including on-site mobile units	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A264	Pharmacy	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A265	Laboratory, including pathology department	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A266	Blood bank	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A270	Emergency department	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A273	Other area within the facility	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A276	Outpatient care area	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A279	Outside area (i.e., grounds of the facility)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor
MANY	Valid CDC Location Code	2.16.840.1.113883.6.259	Healthcare Service Location (HL7)

Maximum Length:	4
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Either an AHRQ Common Formats location code or a valid CDC Location Code can be reported. CDC Location Codes map to AHRQ Common Formats location codes: CDC Location Codes 1038-9, 1051-2 through 1057-9, 1060-3 through 1073-6, 1075-1 through 1086-8, 1099-1 through 1100-7, 1102-3 through 1105-6, 1164-3, 1165-0, 1171-8, 1205-4, 1209-6 through 1212-0, 1214-6, 1217-9, 1218-7, 1221-1, 1226-0 through 1232-8, 1234-4 through 1236-9, 1250-0, 1254-2 through 1260-9 map to AHRQ Common Formats A249 “Inpatient general care area, (e.g., medical/surgical unit.)

	CDC Location Codes 1022-3, 1023-1, 1025-6 through 1035-5, 1039-7 through 1049-6, 1088-4 through 1093-4, 1198-1, 1208-8, 1220-3, 1222-9 through 1225-2, and 1233-6 map to AHRQ Common Formats A252 “Special care area (e.g., ICU, CCU, NICU.)” CDC Location Codes 1058-7 and 1059-5 map to AHRQ Common Formats A255 “Labor and delivery.” CDC Location Codes 1005-8, 1007-4, 1020-7, 1095-9 through 1097-5, 1169-2, 1203-9, 1242-7 through 1247-8, and 1166-8 through 1168-4 map to AHRQ Common Formats A258 “Operating room or procedure area (e.g., cardiac catheter lab, endoscopy area), including PACU or recovery area.” CDC Location Codes 1008-2 and 1175-9 map to AHRQ Common Formats A261 “Radiology/imaging department, including on-site mobile units.” CDC Location Code 1179-1 maps to AHRQ Common Formats A264 “Pharmacy.” CDC Location Codes 1010-8 through 1016-5 map to AHRQ Common Formats A265 “Laboratory, including pathology department.” CDC Location Codes 1147-8, 1176-7, 1185-8, 1195-7, 1207-0, and 1261-7 map to AHRQ Common Formats A266 “Blood bank.” CDC Location Codes 1108-0 and 1109-8 map to AHRQ Common Formats A270 “Emergency Department.” CDC Location Codes 1019-9, 1106-4, 1180-9 through 1184-1, 1186-6, 1187-4, 1189-0, 1190-8, and 1206-2 map to AHRQ Common Formats A273 “Other area within the facility.” CDC Location Codes 1009-0, 1017-3, 1018-1, 1110-6, 1112-2, 1113-0, 1115-5 through 1134-6, 1136-1 through 1146-0, 1148-6 through 1154-4, 1156-9 through 1162-7, 1200-5, and 1202-1 map to AHRQ Common Formats A276 “Outpatient care area.” CDC Location Codes 118-2 and 1188-2 map to AHRQ Common Formats A279 “Outside area (i.e., grounds of the facility.)” Select "Unknown" if the location of the event or unsafe condition is unknown.
References:	www.cdc.gov/nhsn/PDFs/pscManual/15LocationsDescriptions_current.pdf
Collected in Module(s):	Generic
Comments:	None defined at this time.
Description of Change:	Removed: -A267 "Laboratory, including pathology department and blood bank." -A66 "Other: Please specify." Added: -A265 "Laboratory, including pathology department." -A266 "Blood bank." -Answer value for Valid CDC Location Code -Guide for Use text "Either an AHRQ Common Formats location code or a valid CDC Location Code can be reported." -Guide for Use text "CDC Location Codes 1010-8 thru 1016-5 map to AHRQ Common Formats A265 "Laboratory, including pathology department." -Guide for Use text "CDC Location Code 1185-8 maps to AHRQ Common Formats A266 "Blood bank." -Guide for Use text "Select "Unknown" if the location of the event or unsafe condition is unknown." Changed: -Definition text from "Determination of where the event occurred, or if an unsafe condition, where it existed." to "Determination of where the event or unsafe condition occurred." -Question text from "Where did the event occur, or, if an unsafe condition, where did it exist?" to "Where did the event or unsafe condition occur?"
Rationale for Change:	Definition text clarification, Answer value clarification, Guide for Use text clarification, and Question text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Reporter job or position**
Data Element ISO Name:	Reporter-Job or position,CD
Data Element ID:	DE81
Definition:	Determination of who reported the event or unsafe condition.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Who first reported the event or unsafe condition?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A288	Healthcare professional	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A291	Healthcare worker (including nursing assistant, patient transport/retrieval personnel, assistant/orderly, clerical/administrative personnel, interpreter/translator, technical/laboratory personnel, patient care assistant, administrator/manager, housekeeping, maintenance, pastoral care personnel, or biomedical engineer)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A294	Emergency service personnel (including police officer, fire fighter, or other emergency service officer)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A297	Patient, family member, volunteer, caregiver, or homecare assistant	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	4
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	No further information provided.
References:	The International Classification for Patient Safety (ICPS) Taxonomy for Patient Safety 2009 (v1.1): http://www.who.int/patientsafety/implementation/taxonomy/en/
Collected in Module(s):	Generic
Comments:	None defined at this time.
Description of Change:	Removed: -A66 "Other: Please specify" Changed: -Data Element Name from "Reporter type" to "Reporter job or position." -Data Element ISO Name from "Reporter-Type,CD" to "Reporter-Job or position, CD." -Question text from "Who reported the event or unsafe condition?" to "Who first reported the event or unsafe condition?"
Rationale for Change:	Data Element Name clarification, Data Element ISO Name clarification, Question text clarification, and Answer value clarification.

Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Type of healthcare professional reporter**
Data Element ISO Name:	Healthcare professional_Reporter-Type,CD
Data Element ID:	DE84
Definition:	Determination of the type of healthcare professional that reported the event or unsafe condition.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What type of healthcare professional made the initial report?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A303	Doctor, dentist (including student)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A306	Nurse, nurse practitioner, physician assistant (including student or trainee)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A309	Pharmacist, pharmacy technician (including student)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A312	Allied health professionals (including paramedic, speech, physical, or occupational therapist, dietician)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	4
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only if the person who reported the event or unsafe condition was a healthcare professional.
References:	No specific reference at this time.
Collected in Module(s):	Generic
Comments:	None defined at this time.
Description of Change:	Changed: -Question text from "What is the type of healthcare professional?" to "What type of healthcare professional made the initial report?"
Rationale for Change:	Question text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Event discovery date/time**
Data Element ISO Name:	Event-Date/time_Discovery,TS
Data Element ID:	DE9
Definition:	The month, day, year, and time the event (incident or near miss) was discovered.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What is the event discovery date/time?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	24
Multiple Choice:	No
Format:	Refer to Common Formats Resources Workbook (Validation Tab).
Data Type:	Date/Time
HL7 Data Type:	Point in Time (TS)
Guide for Use:	Answer this question only if you are reporting an incident or a near miss. Enter the time the incident was discovered or the near miss was recognized, if you know it. If you do not know the time of discovery, and cannot estimate it, select "Unknown".
References:	No specific reference at this time.
Collected in Module(s):	Generic
Comments:	None defined at this time.
Description of Change:	Changed: -Question from "Event Discovery Date/Time:" to "What is the event discovery date/time?"
Rationale for Change:	Question text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Medication or Other Substance

Data Element Name:	**RXCUI Semantic Clinical Drug (SCD)**
Data Element ISO Name:	RXCUI Semantic Clinical Drug (SCD),CD
Data Element ID:	DE1151
Definition:	The RxNorm concept unique identifier for the ingredient, strength, and dose form for the clinical drug or substance involved in the event (i.e., the SCD RXCUI).
Version:	Hospital Version 2.0
Question:	What is the RXCUI Semantic Clinical Drug (SCD) of the medication?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
MANY	MANY	2.16.840.1.113883.6.88	RxNorm

Maximum Length:	8
Multiple Choice:	No
Format:	Refer to Common Formats Resources Workbook (Validation Tab).
Data Type:	Numeric
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	RxNorm concept unique identifier (RXCUI): This RXCUI always designates the same concept, no matter the form of the name and no matter in what table it is found. Drugs whose names map to the same RXCUI are taken to be the same drug, identical as to ingredients, strengths, and dose forms. Conversely, drugs that differ in any of these particulars are conceptually distinct and will have different RXCUIs. SCD RXCUI: The RxNorm concept unique identifier for the ingredient, strength, and dose form for a clinical drug or substance.
References:	Answer values are from the RxNorm Code System (Code System OID: 2.16.840.1.113883.6.88). https://rxnav.nlm.nih.gov/
Collected in Module(s):	Medication or Other Substance
Comments:	None defined at this time.
Description of Change:	N/A
Rationale for Change:	N/A
Start Date:	12/16/2016
Update Date:	N/A

Data Element Name:	**Type of substance involved**
Data Element ISO Name:	Event_Medication-Substance_Type,CD
Data Element ID:	DE270
Definition:	Determination of the type of medication/substance involved in the event or unsafe condition.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What type of medication/substance was involved?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A1197	Medications	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1200	Biological products	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1209	Medical gases	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1212	Contrast media	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1213	Radiopharmaceuticals	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A66	Other: Please specify	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	5 (2000 for free text associated with "Other: Please specify" response.)
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	The substances whose use is covered by the Medications or Other Substances Common Formats are articles or substances regulated by the Food and Drug Administration (FDA). See, Title 21, Code of Federal Regulations (CFR). "Medications" are a type of drug. "Biological products" means any virus, therapeutic serum, toxin, antitoxin, or analogous product, including plasma derivatives, applicable to the prevention, treatment or cure of disease or injury. 21 CFR 600.3(h) "Medical gases" also include medical air or an inhalation anesthetic and, when manufactured, packaged and intended for administration to a patient in anesthesia, therapy or diagnosis, constitutes a type of drug. "Contrast media" constitutes a type of drug. They are used to enhance the contrast of structures or fluids within the body during medical imaging. "Radiopharmaceuticals" are a radioactive chemical or pharmaceutical preparation that is labeled with a radionuclide in tracer or therapeutic concentration and this is used as a diagnostic or therapeutic agent. "Other: Please specify" refers to any substance involved not listed, including nutritional substances.
References:	No specific reference at this time.
Collected in Module(s):	Medication or Other Substance
Comments:	None defined at this time.
Description of Change:	Removed: -A1203 "Nutritional products" -A1206 "Expressed human breast milk" -A1214 "Patient food (not suspected in drug-food interactions)" -A1216 "Drug-drug, drug-food, or adverse drug reaction as a result of a prescription and/or administration of a drug and/or food prior to admission" -A1215 "Other substance: Please specify" -Guide for Use text "'Expressed human breast milk' is human breast milk that was produced by manipulating the lactating breast, either by hand or with a breast pump." -Guide for Use text "A 'nutritional product', for the purposes of these Common Formats, does not include "conventional" food." Added: -A66 "Other: Please specify" -Guide for Use text ""Other: Please specify" refers to any substance involved not listed, including

	nutritional substances." Changed: -Definition text from "Determination of the type of medication/substance involved in the event." to "Determination of the type of medication/substance involved in the event or unsafe condition." -A1209 from "Medical gases (e.g., oxygen, nitrogen, nitrous oxide)" to "Medical gases" -Guide for Use text from ""Biological products" means any virus, therapeutic serum, toxin, antitoxin, or analogous product applicable to the prevention, treatment or cure of disease or injury. 21 CFR 600.3" to ""Biological products" means any virus, therapeutic serum, toxin, antitoxin, or analogous product, including plasma derivatives, applicable to the prevention, treatment or cure of disease or injury. 21 CFR 600.3(h)"
Rationale for Change:	Definition text clarification, Answer value clarification, and Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Type of medication involved**
Data Element ISO Name:	Medication-Type,CD
Data Element ID:	DE273
Definition:	The type of medication involved in the event or unsafe condition.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What type of medication was involved in the event or unsafe condition?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A1218	Prescription or over-the-counter	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1221	Compounded preparations	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1224	Investigational drugs	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	5
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	"Prescription or over-the-counter" medications are available commercially in final form. "Compounded preparations" require the intercession of an authorized compounder and are not available off the shelf. They are prepared by mixing two or more drugs or compounds, thus the name. "Investigational drugs" as used here, are drugs that have not yet been approved for marketing by the Food and Drug Administration (FDA) and are not freely available to the public. They are available only as part of a clinical trial, for emergency use, or for serious or life-threatening conditions prior to completion of final clinical work and FDA review. Select "Unknown" if the type of medication involved in the event was not captured.
References:	No specific reference at this time.
Collected in Module(s):	Medication or Other Substance
Comments:	None defined at this time.
Description of Change:	Added: -Guide for Use text "Select "Unknown" if the type of medication involved in the event was not captured." Changed: -Question text from "What type of medication?" to "What type of medication was involved in the event or unsafe condition?" -Definition text from "The type of medication involved in the event." to "The type of medication involved in the event or unsafe condition." -A1218 from "Prescription or over-the-counter (including herbal supplements)" to "Prescription or over-the-counter."
Rationale for Change:	Definition text clarification, Question text clarification, and Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Type of biological product**
Data Element ISO Name:	Biological product-Type,CD
Data Element ID:	DE279
Definition:	The type of biological product involved in the event or unsafe condition.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What type of biological product was involved in the event or unsafe condition?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A1233	Vaccines	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A66	Other: Please specify	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	5 (2000 for free text associated with "Other: Please specify" response.)
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	"Vaccines" are a biological preparation that improves immunity to a particular disease. A vaccine typically contains an agent that resembles a disease-causing microorganism, and is often made from weakened or killed forms of the microbe, its toxins or one of its surface proteins. "Other: Please specify" refers to any type of biological product involved in the event not listed (e.g., thrombolytics, IVIG, albumin, and other plasma derivatives).
References:	No specific reference at this time.
Collected in Module(s):	Medication or Other Substance
Comments:	None defined at this time.
Description of Change:	Removed: -A1236 "Other biological products (e.g., thrombolytic)" Added: -A66 "Other: Please specify" Changed: -Question text from "What type of biological product?" to "What type of biological product was involved in the event or unsafe condition?" -Definition text from "The type of biological product involved in the event." to "The type of biological product involved in the event or unsafe condition." -Guide for Use text from "No further information provided." to ""Vaccines" are a biological preparation that improves immunity to a particular disease. A vaccine typically contains an agent that resembles a disease-causing microorganism, and is often made from weakened or killed forms of the microbe, its toxins or one of its surface proteins. "Other: Please specify" refers to any type of biological product involved in the event not listed (e.g., thrombolytics, IVIG, albumin, and other plasma derivatives)."
Rationale for Change:	Definition text clarification, Question text clarification, Answer value clarification, and Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Incorrect process involving a substance**
Data Element ISO Name:	Event_Medication-Incorrect process_Type,CD
Data Element ID:	DE291
Definition:	The incorrect process involving the medication/substance.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What was the incorrect process involving the medication/substance?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A585	Incorrect patient	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1272	Incorrect medication/substance	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1275	Incorrect dose	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1278	Incorrect route of administration	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1281	Incorrect timing	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1284	Incorrect rate	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1287	Incorrect duration of administration or course of therapy	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1290	Incorrect dosage form (e.g., enteric coating, sustained release, capsule, tablet)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1293	Incorrect strength or concentration	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1296	Incorrect preparation, including inappropriate cutting of tablets, error in compounding, mixing, etc.	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1299	Expired or deteriorated medication/substance	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1303	Adverse drug reaction: patient known to be allergic or sensitive to the medication or substance	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1304	Adverse drug reaction: patient not known to be allergic or sensitive to the medication or substance	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1305	Medication or substance that is known to be contraindicated for a reason other than patient allergy or sensitivity	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1308	Incorrect action by patient or family (e.g., self-administration error)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Value Domain:	Answer Code	Answer Value	Code System	Code System Name
	A66	Other: Please specify	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	5 (2000 for free text associated with "Other: Please specify" response.)
Multiple Choice:	Yes
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	This Data Element is for Incidents and Near Misses only.
References:	No specific reference at this time.
Collected in Module(s):	Medication or Other Substance
Comments:	None defined at this time.
Description of Change:	Removed: -A1302 "Medication/substance that is known to be an allergen to the patient" Added: -A1303 "Adverse drug reaction: patient known to be allergic or sensitive to the medication or substance" -A1304 "Adverse drug reaction: patient not known to be allergic or sensitive to the medication or substance" Changed: -Data Element name from "Incorrect action(s) involving a substance" to "Incorrect process involving a substance" -Data Element ISO Name from "Event_Medication-Incorrect action_Type,CD" to "Event_Medication-Incorrect process_Type,CD" -Definition text from "The incorrect action that occurred in the medication/substance event." to "The incorrect process that occurred in the medication/substance event." -Question text from "What was the incorrect action?" to "What was the incorrect process involving the medication/substance?" -A1290 from "Incorrect dosage form (e.g., sustained release instead of immediate release)" to "Incorrect dosage form (e.g., enteric coating, sustained release, capsule, tablet)" -A1305 from "Medication or substance that is known to be contraindicated for the patient" to "Medication or substance that is known to be contraindicated for a reason other than patient allergy or sensitivity" -A1308 from "Incorrect patient/family action (e.g., self-administration error)" to "Incorrect action by patient or family (e.g., self-administration error)" -Guide for Use text from "No further information provided." to "This Data Element is for Incidents and Near Misses only."
Rationale for Change:	Data Element Name clarification, Data Element ISO name clarification, Definition text clarification, Question text clarification, and Answer value clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Medication or substance contraindication not involving allergy**
Data Element ISO Name:	Medication-Contraindication-Allergy,CD
Data Element ID:	DE313
Definition:	The type of known contraindication not involving allergy or sensitivity for administration of the medication or substance.
Version:	Hospital Version 2.0
Question:	What was the known contraindication (potential or actual interaction) for this medication or substance other than patient allergy or sensitivity?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A1368	Drug-drug	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1371	Drug-food	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1374	Drug-disease	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	5
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	This Data Element is for Incidents and Near Misses only.
References:	No specific reference at this time.
Collected in Module(s):	Medication or Other Substance
Comments:	None defined at this time.
Description of Change:	N/A
Rationale for Change:	N/A
Start Date:	5/18/2017
Update Date:	N/A

Data Element Name:	**Stage event originated**
Data Element ISO Name:	Event_Medication-Stage_Origination,CD
Data Element ID:	DE315
Definition:	The stage in the process the event originated.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	At what stage in the process did the event originate, regardless of the stage at which it was discovered?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A1380	Purchasing	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1383	Storing	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1386	Prescribing/ordering	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1389	Transcribing	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1392	Preparing	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1395	Dispensing	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1398	Administering	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1401	Monitoring	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor
A66	Other: Please specify	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	5 (2000 for free text associated with "Other: Please specify" response.)
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	This Data Element is for Incident and Near Misses only. "Purchasing" includes purchasing for stock or for a particular patient. "Storing" includes maintaining the substance under special environmental conditions and in accordance with appropriate security requirements. "Prescribing/ordering" means the issuance of an order by an authorized professional for the delivery or administration of a substance to a patient. Prescribing/ordering may be done in writing, verbally or through an electronic order entry system. "Transcribing" includes documenting verbal orders in writing or electronically, entering written orders into an electronic system, and copying orders for separate uses. "Preparing" includes taking substances from stock, manipulating them, compounding, and measuring and apportioning doses, such as the filling of cartridges and unit-dose syringes. "Dispensing" includes assuring accurate labeling of the prepared substance, issuance of the substance from the pharmacy, and delivery by pharmacy personnel to the patient care area. "Administering" generally occurs in a patient care area and includes checking orders and patient identity and delivering the substance to the patient either by oral ingestion or by direct application, such as by injection, insertion, or topical application, or with the use of indwelling lines, tubes or catheters. "Monitoring" includes measuring and observing to determine the presence or absence of the desired effect of the substance administered and to detect any unintended adverse effects. Select "Unknown" if the stage in process is unknown. Select "Other: Please specify" if the stage in the process where the event originated is not listed in the above described answer values.

References:	No specific reference at this time.
Collected in Module(s):	Medication or Other Substance
Comments:	None defined at this time.
Description of Change:	Added: -Guide for Use text "This Data Element is for Incident and Near Misses only. " -Guide for Use text "Select "Unknown" if the stage in process is unknown." -Guide for Use text "Select "Other: Please specify" if the stage in the process where the event originated is not listed in the above described answer values."
Rationale for Change:	Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**RXCUI brand name (BN)**
Data Element ISO Name:	Product-Brand name_ RXCUI,CD
Data Element ID:	DE322
Definition:	The RxNorm concept unique identifier for the brand name for the clinical drug or substance involved in the event or unsafe condition (i.e., the RXCUI Brand name).
Version:	Hospital Version 1.2; Hospital Version 2.0
Question:	If appropriate, what is the RXCUI brand name (BN) of the medication?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
MANY	MANY	2.16.840.1.113883.6.88	RxNorm

Maximum Length:	8
Multiple Choice:	No
Format:	Refer to Common Formats Resources Workbook (Validation Tab).
Data Type:	Numeric
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	RxNorm concept unique identifier (RXCUI): This RXCUI always designates the same concept, no matter the form of the name and no matter in what table it is found. Drugs whose names map to the same RXCUI are taken to be the same drug, identical as to ingredients, strengths, and dose forms. Conversely, drugs that differ in any of these particulars are conceptually distinct and will have different RXCUIs. RXCUI brand name: RxNorm concept unique identifier for a proprietary name for a family of products containing a specific active ingredient.
References:	answer values are from the RxNorm Code System (Code System OID: 2.16.840.1.113883.6.88). https://rxnav.nlm.nih.gov/
Collected in Module(s):	Medication or Other Substance
Comments:	None defined at this time.
Description of Change:	Changed: -Data Element name from "RXCUI brand name" to "RXCUI brand name (BN)" -Definition text from "The RxNorm concept unique identifier for the brand name, for the clinical drug or substance involved in the event" to "The RxNorm concept unique identifier for the brand name for the clinical drug or substance involved in the event or unsafe condition (i.e., the RXCUI Brand name)." -Question text from "Brand name RXCUI (if known)" to "If appropriate, what is the RXCUI brand name (BN) of the medication?"
Rationale for Change:	Data Element Name clarification, Definition text clarification, and Question text clarification.
Start Date:	4/3/2012
Update Date:	5/18/2017

Data Element Name:	**Medication/substance prescribed**
Data Element ISO Name:	Medication/substance-Prescribed,CD
Data Element ID:	DE333
Definition:	Determination of whether the medication/substance was prescribed for this patient.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Was this medication/substance prescribed for this patient?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A15	Yes	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A18	No	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	3
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only if the concern was an incident or a near miss (not an unsafe condition). Do not include information about compounded preparations when responding.
References:	No specific reference at this time.
Collected in Module(s):	Medication or Other Substance
Comments:	None defined at this time.
Description of Change:	Changed: -Definition text from "Determination of the medication/substance prescribed for this patient." to "Determination of whether the medication/substance was prescribed for this patient." -Guide for Use text from "Do not include information about compounded preparations or expressed breast milk when responding." to "Answer this question only if the concern was an incident or a near miss (not an unsafe condition). Do not include information about compounded preparations when responding."
Rationale for Change:	Definition text clarification and Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Medication/substance given**
Data Element ISO Name:	Medication/substance-Given,CD
Data Element ID:	DE336
Definition:	Determination if the medication/substance was given to this patient.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Was this medication/substance given to this patient?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A15	Yes	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A18	No	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	3
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only if the concern was an incident (i.e., not a near miss or an unsafe condition). Do not include information about compounded preparations when responding.
References:	No specific reference at this time.
Collected in Module(s):	Medication or Other Substance
Comments:	None defined at this time.
Description of Change:	Changed: -Guide for Use text from "Do not include information about compounded preparations or expressed breast milk when responding." to "Do not include information about compounded preparations when responding."
Rationale for Change:	Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Perinatal

Data Element Name:	**Type of perinatal event**
Data Element ISO Name:	Type-Event_Perinatal,CD
Data Element ID:	DE353
Definition:	The type of perinatal event.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Which of the following did the event involve?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A1516	Birthing process (labor and delivery)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1517	Intrauterine procedure (prenatal)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A342	Other	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	5
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Check one answer value. Select "Birthing process (labor and delivery)" if the event involved labor or delivery, including delivery of the placenta. Select "Intrauterine procedure (prenatal)" if the event involved an intrauterine procedure that occurred during the perinatal period but prior to the birthing process. Select "Other" if the type of event involved was not listed. Select "Unknown" if the type of event involved is not known.
References:	No specific reference at this time.
Collected in Module(s):	Perinatal
Comments:	None defined at this time.
Description of Change:	N/A
Rationale for Change:	N/A
Start Date:	3/31/2010
Update Date:	N/A

Data Element Name:	**Patient(s) affected by perinatal event**
Data Element ISO Name:	Event_Perinatal-Affected_Patient,CD
Data Element ID:	DE354
Definition:	The patient(s) affected by the perinatal event.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Who was affected by the perinatal event?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A1518	Mother	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1519	Fetus(es)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1525	Neonate(s)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	5
Multiple Choice:	Yes
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	The mother may be affected during a prenatal intrauterine procedure or during the birthing process. A fetus may be affected during a prenatal intrauterine procedure or during the birthing process. If a fetus is injured during a prenatal intrauterine procedure and the injury is not discovered until after a live birth, the injury should be reported as affecting a neonate. A neonate may be affected during a prenatal intrauterine procedure or during the birthing process. Once a fetus is born alive, any injury that occurred prior to birth should be reported as affecting a neonate. Enter/check all that apply. Acceptable combinations are: -mother and fetus -mother and neonate
References:	No specific reference at this time.
Collected in Module(s):	Perinatal
Comments:	None defined at this time.
Description of Change:	Added: -Guide for Use text "Enter/check all that apply. Acceptable combinations are: mother and fetus; mother and neonate." Changed: -Definition text from "The patient affected by the perinatal event." to "The patient(s) affected by the perinatal event." -Question text from "Who was affected by the event?" to "Who was affected by the perinatal event?"
Rationale for Change:	Guide for Use text clarification, Definition text clarification, and Question text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Gestational age prior to birth**
Data Element ISO Name:	Gestational age_Estimate-Prior to birth_Immediately,CD
Data Element ID:	DE363
Definition:	The gestational age prior to birth or at the time of the intrauterine procedure (prenatal).
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Immediately prior to birth, or at the time of the intrauterine procedure (prenatal), what was the best estimate of completed weeks of gestation?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A1539	Greater than or equal to 20 weeks but less than 36 weeks	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1542	Greater than or equal to 36 weeks but less than 38 weeks	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1545	Greater than or equal to 38 weeks but less than 42 weeks	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1548	42 weeks or more	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	5
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Gestational age is generally calculated on the basis of the mother's last menstrual period or via ultrasound.
References:	http://browser.ihtsdotools.org/?
Collected in Module(s):	Perinatal
Comments:	None defined at this time.
Description of Change:	Common Formats Hospital 2.0 changed the language from using the term "delivery" to using the term "birth." Changed: -Data Element Name from "Gestational age prior to delivery" to "Gestational age prior to birth" -Data Element ISO Name from "Gestational age_Estimate-Prior to delivery_Immediately,CD" to "Gestational age_Estimate-Prior to birth_Immediately,CD" -Definition text from "The gestational age prior to delivery or at the time of the intrauterine procedure (perinatal)" to "The gestational age prior to birth or at the time of the intrauterine procedure (prenatal)." -Question text from “Immediately prior to delivery, or at the time of the intrauterine procedure (prenatal), what was the best estimate of completed weeks of gestation?” to “Immediately prior to birth, or at the time of the intrauterine procedure (prenatal), what was the best estimate of completed weeks of gestation?” -Guide for Use text from "Gestational age is generally calculated on the basis of the mother's last menstrual period. It is sometimes confirmed by ultrasound" to "Gestational age is generally calculated on the basis of the mother's last menstrual period or via ultrasound." -A1539 from "20-< 36 weeks" to "Greater than or equal to 20 weeks but less than 36 weeks" -A1542 from "36-< 38 weeks" to "Greater than or equal to 36 weeks but less than 38 weeks" -A1545 from "38-< 42 weeks" to "Greater than or equal to 38 weeks but less than 42 weeks"
Rationale for Change:	Data Element Name clarification, Data Element ISO Name clarification, Definition text clarification, Answer value clarification, and Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Whether labor induced or augmented**
Data Element ISO Name:	Event-Labor_Induced or Augmented,CD
Data Element ID:	DE366
Definition:	Determination if labor was either induced or augmented.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Was labor induced or augmented?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A15	Yes	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A18	No	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	3
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only if the incident involved the birthing process, regardless of who was affected by the incident. Select "Yes" if labor was either induced or augmented, or both. Select "No" if labor was neither induced nor augmented. Select "Unknown" if you do not know whether labor was induced or augmented, or if you do not know which of those two methods was used.
References:	No specific reference at this time.
Collected in Module(s):	Perinatal
Comments:	None defined at this time.
Description of Change:	Changed: -Guide for Use text from "Answer this question only if the incident involved the birthing process, regardless of who was affected by the incident. Select "Unknown" if you do not know whether the mother's labor was induced or augmented, or if you do not know which of those two methods was used." to "Answer this question only if the incident involved the birthing process, regardless of who was affected by the incident. Select "Yes" if labor was either induced or augmented, or both. Select "No" if labor was neither induced nor augmented. Select "Unknown" if you do not know whether labor was induced or augmented, or if you do not know which of those two methods was used."
Rationale for Change:	Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Final mode of birth**
Data Element ISO Name:	Birth-Mode,CD
Data Element ID:	DE372
Definition:	Determination of the final mode of birth.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What was the mode of birth?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
289259007	Vaginal Delivery	2.16.840.1.113883.6.96	SNOMED CT
A1569	Trial of labor followed by Cesarean birth	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
200146002	Cesarean section	2.16.840.1.113883.6.96	SNOMED CT
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	9
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only if the incident involved the birthing process, regardless of who was affected by the incident. If the process began as a planned vaginal delivery and was converted to a Cesarean section, select "Cesarean section." Select "Unknown" if you do not know the final mode of birth.
References:	Answer values are from the SNOMED CT Code System (Code System OID: 2.16.840.1.113883.6.96). http://browser.ihtsdotools.org/?
Collected in Module(s):	Perinatal
Comments:	None defined at this time.
Description of Change:	Common Formats Hospital 2.0 changed the language from using the term "delivery" to using the term "birth." Changed: -Data Element Name from "Final mode of delivery" to "Final mode of birth" -Data Element ISO Name from "Delivery-Mode,CD" to "Birth-Mode,CD" -Definition text from "Determination of the final mode of delivery." to "Determination of the final mode of birth." -A1569 from "Attempted vaginal delivery followed by Cesarean section" to "Trial of labor followed by Cesarean birth" -Question text from "What was the mode of delivery?" to "What was the mode of birth?" -Guide for Use text from "Answer this question only if the incident involved the birthing process, regardless of who was affected by the incident. If the process began as a planned vaginal delivery was converted to a Cesarean section, select "Cesarean section." to "Answer this question only if the incident involved the birthing process, regardless of who was affected by the incident. If the process began as a planned vaginal delivery and was converted to a Cesarean section, select "Cesarean section." Select "Unknown" if you do not know the final mode of birth."
Rationale for Change:	Data Element Name clarification, Data Element ISO Name clarification, Definition text clarification, Question text clarification, Guide for Use text clarification, and Answer value clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Vaginal birth with instrumentation assistance**
Data Element ISO Name:	Birth_Vaginal-Instrumentation,CD
Data Element ID:	DE375
Definition:	Determination if instrumentation was used to assist with vaginal (or attempted vaginal) birth.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Regardless of the final mode of birth, was instrumentation used to assist vaginal (or attempted vaginal) birth?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A15	Yes	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A18	No	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	3
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only if the incident involved the birthing process, regardless of who was affected by the incident. Examples of instrumentation include vacuum extraction and/or the use of forceps.
References:	No specific reference at this time.
Collected in Module(s):	Perinatal
Comments:	None defined at this time.
Description of Change:	Common Formats Hospital 2.0 changed the language from using the term "delivery" to using the term "birth." Changed: -Data Element Name from "Vaginal delivery with instrumentation assistance" to "Vaginal birth with instrumentation assistance" -Data Element ISO Name from "Delivery_Vaginal-Instrumentation,CD" to "Birth_Vaginal-Instrumentation,CD" -Definition text from "Determination if instrumentation was used to assist with vaginal (or attempted vaginal) delivery" to "Determination if instrumentation was used to assist with vaginal (or attempted vaginal) birth" -Question text from "Regardless of the final mode of delivery, was instrumentation used to assist vaginal (or attempted vaginal) delivery?" to "Regardless of the final mode of birth, was instrumentation used to assist vaginal (or attempted vaginal) birth?" -Guide for Use text from "Answer this question only if the incident involved the birthing process, regardless of who was affected by the incident. Examples of instrumentation include vacuum extraction and the use of forceps." to "Answer this question only if the incident involved the birthing process, regardless of who was affected by the incident. Examples of instrumentation include vacuum extraction and/or the use of forceps."
Rationale for Change:	Data Element Name clarification, Data Element ISO Name clarification, Question text clarification, Definition text clarification, and Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Type of maternal adverse outcome(s)**
Data Element ISO Name:	Adverse outcome-Maternal,CD
Data Element ID:	DE381
Definition:	The adverse outcome(s) sustained by the mother.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Which adverse outcome(s) did the mother sustain?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A1596	Death	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1599	Hemorrhage requiring transfusion	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1602	Eclampsia	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1605	Magnesium toxicity	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1608	Infection (not present on admission)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1611	Injury to body part, organ, or vasculature	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A66	Other: Please specify	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	5 (2000 for free text associated with "Other: Please specify" response.)
Multiple Choice:	Yes
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only if the event involved the mother. Select "Other: Please specify" if the adverse maternal outcome is not listed in the above answer values.
References:	No specific reference at this time.
Collected in Module(s):	Perinatal
Comments:	None defined at this time.
Description of Change:	Changed: -A1608 from "Infection" to "Infection (not present on admission)" -A1611 from "Injury to body part or organ" to "Injury to body part, organ, or vasculature." -Guide for Use text from "Answer this question only if the event involved the mother." to "Answer this question only if the event involved the mother. Select "Other: Please specify" if the adverse maternal outcome is not listed in the above answer values."
Rationale for Change:	Answer value clarification and Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Type of fetus adverse outcome**
Data Element ISO Name:	Adverse outcome-Fetus,CD
Data Element ID:	DE390
Definition:	Determination of what adverse outcome was sustained by the fetus.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Which adverse outcome did the fetus sustain?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A1644	Unexpected death	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1647	Injury	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	5
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only if the event affected a fetus.
References:	No specific reference at this time.
Collected in Module(s):	Perinatal
Comments:	None defined at this time.
Description of Change:	N/A
Rationale for Change:	N/A
Start Date:	3/31/2010
Update Date:	4/3/2012

Data Element Name:	**Neonate/stillborn birthweight**
Data Element ISO Name:	Birthweight-Neonate/stillborn_grams,PQ
Data Element ID:	DE394
Definition:	Neonate's birthweight or weight of stillborn entered in grams.
Version:	Hospital Version 1.2; Hospital Version 2.0
Question:	What was the neonate's birthweight (or weight of stillborn)?
Value Domain:	N/A
Maximum Length:	7
Multiple Choice:	No
Format:	N/A
Data Type:	Numeric
HL7 Data Type:	Physical Quantity (PQ)
Guide for Use:	Answer this question only if the incident involved the birthing process and regardless of who was affected by the incident. In the case of a live birth from a single pregnancy, enter the birthweight (in grams) of the neonate. In the case of a stillborn from a single pregnancy, enter the weight (in grams) of the stillborn. In the case of a multiple pregnancy, enter the weight (in grams) of the heaviest of all neonate(s) and/or fetus(es). Weights of the other neonate(s) and/or fetus(es) may be added in the narrative description of the incident.
References:	No specific reference at this time.
Collected in Module(s):	Perinatal
Comments:	None defined at this time.
Description of Change:	N/A
Rationale for Change:	N/A
Start Date:	4/3/2012
Update Date:	N/A

Data Element Name:	**Type of neonatal adverse outcome(s)**
Data Element ISO Name:	Adverse outcome-Neonate,CD
Data Element ID:	DE399
Definition:	Adverse outcome sustained by the neonate.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Which adverse outcome(s) did the neonate sustain?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A1644	Unexpected death	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1660	Birth trauma/injury	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1662	Five-minute Apgar less than 7 and birthweight greater than 2500 grams	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1665	Hypoxic ischemic encephalopathy (HIE)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1668	Seizure(s)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1671	Infection (e.g., group B strep)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A66	Other: Please specify	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	5 (2000 for free text associated with "Other: Please specify" response.)
Multiple Choice:	Yes
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only if the event affected a neonate. Select "Other: Please specify" if the adverse neonatal outcome is not listed in the above answer values. Birth trauma listed under ICD-9-CM 767 include the following: 767.0 Subdural and cerebral hemorrhage 767.1 Injuries to scalp 767.2 Fracture of clavicle 767.3 Other injuries to skeleton 767.4 Injury to spine and spinal cord 767.5 Facial nerve injury 767.6 Injury to brachial plexus Palsy or paralysis: brachial Erb (-Duchenne) Klumpke (-Dejerine) 767.7 Other cranial and peripheral nerve injuries 767.8 Other specified birth trauma 767.9 Birth trauma, unspecified https://www.cms.gov/medicare/coding/ICD9providerdiagnosticcodes/codes.html Birth trauma listed under ICD-10-CM P10-15 include the following: P.10 Subdural haemorrhage due to birth injury P10.1 Cerebral haemorrhage due to birth injury P10.2 Intraventricular haemorrhage due to birth injury P10.3 Subarachnoid haemorrhage due to birth injury P10.4 Tentorial tear due to birth injury P10.8 Other intracranial lacerations and haemorrhages due to birth injury

P10.9 Unspecified intracranial laceration and haemorrhage due to birth injury
P11 Other birth injuries to central nervous system
P11.0 Cerebral oedema due to birth injury
P11.1 Other specified brain damage due to birth injury
P11.2 Unspecified brain damage due to birth injury
P11.3 Birth injury to facial nerve
P11.4 Birth injury to other cranial nerves
P11.5 Birth injury to spine and spinal cord
P11.9 Birth injury to central nervous system, unspecified
P12 Birth injury to scalp
P12.0 Cephalhaematoma due to birth injury
P12.1 Chignon due to birth injury
P12.2 Epicranial subaponeurotic haemorrhage due to birth injury
P12.3 Bruising of scalp due to birth injury
P12.4 Monitoring injury of scalp of newborn
P12.8 Other birth injuries to scalp
P12.9 Birth injury to scalp, unspecified
P13 Birth injury to skeleton
P13.0 Fracture of skull due to birth injury
P13.1 Other birth injuries to skull
P13.2 Birth injury to femur
P13.3 Birth injury to other long bones
P13.4 Fracture of clavicle due to birth injury
P13.8 Birth injuries to other parts of skeleton
P13.9 Birth injury to skeleton, unspecified
P14 Birth injury to peripheral nervous system
P14.0 Erb paralysis due to birth injury
P14.1 Klumpke paralysis due to birth injury
P14.2 Phrenic nerve paralysis due to birth injury
P14.3 Other brachial plexus birth injuries
P14.8 Birth injuries to other parts of peripheral nervous system
P14.9 Birth injury to peripheral nervous system, unspecified
P15 Other birth injuries
P15.0 Birth injury to liver
P15.1 Birth injury to spleen
P15.2 Sternomastoid injury due to birth injury
P15.3 Birth injury to eye
P15.4 Birth injury to face
P15.5 Birth injury to external genitalia
P15.6 Subcutaneous fat necrosis due to birth injury
P15.8 Other specified birth injuries
P15.9 Birth injury, unspecified
http://apps.who.int/classifications/icd10/browse/2016/en#/XV

References:	No specific reference at this time.
Collected in Module(s):	Perinatal
Comments:	None defined at this time.
Description of Change:	Added: -ICD-10 codes for birth trauma -Guide for Use text "Other: Please specify" if the adverse neonatal outcome is not listed in the above answer values." Changed: -A1660 from "Birth trauma/injury as listed under ICD-9-CM767 or ICD-10-CMP10-P15" to "Birth trauma/injury" -A1662 from "Five-minute Apgar < 7 and birthweight > 2500 grams" to "Five-minute Apgar less than 7 and birthweight greater than 2500 grams" -A1665 from "Anoxic or hypoxic encephalopathy" to "Hypoxic ischemic encephalopathy (HIE)."

Rationale for Change:	Conversion from use of ICD-9 to ICD-10 in the clinical setting and Answer value clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Pressure Injury

Data Element Name:	**Status of Stage 2 pressure injury on admission**
Data Element ISO Name:	Stage 2-Status_On admission,CD
Data Element ID:	DE2012
Definition:	The status of the Stage 2 pressure injury on admission.
Version:	Hospital Version 2.0
Question:	What was the status on admission of the Stage 2 pressure injury?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A1701	Stage 2	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1698	Stage 1	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1716	Not present	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	5
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Select "Stage 1" if the most advanced stage of the pressure injury being reported was intact skin with non-blanchable redness of a localized area usually over a bony prominence. Select "Stage 2" if the most advanced stage of the pressure injury being reported was partial-thickness tissue loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. Select "Not present" if the Stage 2 pressure injury was not present on admission. Select "Unknown" if the status of the Stage 2 pressure injury on admission is unknown.
References:	National Pressure Ulcer Advisory Panel http://www.npuap.org/resources
Collected in Module(s):	Pressure Injury
Comments:	None defined at this time.
Description of Change:	N/A
Rationale for Change:	N/A
Start Date:	5/18/2017
Update Date:	N/A

Data Element Name:	**Risk assessment documented**
Data Element ISO Name:	Risk Assessment_Documented-Prior to Event,CD
Data Element ID:	DE2015
Definition:	Determination if pressure injury risk assessment was documented prior to the event.
Version:	Hospital Version 2.0
Question:	Was a pressure injury risk assessment documented prior to the event?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A15	Yes	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A18	No	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	3
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Select "Yes" if a pressure injury risk assessment was documented in accordance with this facility's internal policies and procedures prior to the event. Select "No" if a pressure injury risk assessment was not documented in accordance with this facility's internal policies and procedures prior to the event. Select "Unknown" if you do not know if a pressure injury risk assessment was documented in accordance with this facility's internal policies and procedures prior to the event. "Event" refers to any of the following: (1) development of a new pressure injury, (2) advancement of a present on admission pressure injury, (3) development of a Deep Tissue Pressure Injury (DTPI), (4) development of a mucosal pressure injury, or (5) development of a secondary morbidity attributed to any pressure injury of the skin or mucous membrane.
References:	No specific reference at this time.
Collected in Module(s):	Pressure Injury
Comments:	None defined at this time.
Description of Change:	N/A
Rationale for Change:	N/A
Start Date:	5/18/2017
Update Date:	N/A

Data Element Name:	**Most advanced stage of pressure injury or DTPI reported**
Data Element ISO Name:	Pressure injury_Being reported-Advancement,CD
Data Element ID:	DE408
Definition:	Determination of the most advanced stage of the pressure injury or deep tissue pressure injury (DTPI) being reported.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What was the most advanced stage/type of the pressure injury or deep tissue pressure injury (DTPI) being reported?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A1698	Stage 1	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1701	Stage 2	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1713	Deep Tissue Pressure Injury (DTPI)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1704	Stage 3	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1707	Stage 4	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1710	Unstageable	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1711	Mucosal pressure injury not present on admission	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A66	Other: Please specify	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	5 (2000 for free text associated with "Other: Please specify" response.)
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Select "Stage 1" if the most advanced stage of the pressure injury being reported was intact skin with non-blanchable redness of a localized area usually over a bony prominence. Select "Stage 2" if the most advanced stage of the pressure injury being reported was partial-thickness tissue loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. Select "Deep Tissue Pressure Injury (DTPI)" if the most advanced stage of the pressure injury being reported was intact or non-intact skin with non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. Select "Stage 3" if the most advanced stage of the pressure injury being reported was full-thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Select "Stage 4" if the most advanced stage of the pressure injury being reported was full-thickness tissue loss with exposed bone, tendon or muscle. Select "Unstageable" if the most advanced stage of pressure injury being reported was full-thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed. Select "Mucosal pressure injury not present on admission" if the most advanced stage of pressure injury being reported was found on mucous membranes with a history of a medical device in use at the location of the injury. Select "Other: Please specify" if the most advanced stage of pressure injury being reported is not listed in the above answer values. Select "Unknown" if the most advanced stage of pressure injury being reported is unknown. Report the most severe pressure injury if only one will be reported. Submit separate reports for each pressure injury identified and link the reports if multiple pressure injuries will be reported.

References:	National Pressure Ulcer Advisory Panel http://www.npuap.org/resources
Collected in Module(s):	Pressure Injury
Comments:	None defined at this time.
Description of Change:	Common Format Hospital 2.0 changed the language from using the term "Pressure Ulcer" to "Pressure Injury", consistent with a change by the National Pressure Ulcer Advisory Panel (NPUAP). Added: -Guide for Use text for "Deep Tissue Pressure Injury (DTPI)", "Mucosal pressure injury not present on admission", "Other: Please specify", and "Unknown". -Guide for Use text for reporting multiple pressure injuries. Changed: -Data Element Name from "Most advanced stage of pressure ulcer of sDTI reported" to "Most advanced stage of pressure injury or DTPI reported" -Data Element ISO Name from "Pressure ulcer_Being reported-Advancement,CD" to "Pressure injury_Being reported-Advancement,CD" -Definition text from "Determination of the most advanced stage of the pressure ulcer or suspected deep tissue injury being reported" to "Determination of the most advanced stage of the pressure injury or deep tissue pressure injury (DTPI) being reported." -Question text from "What was the most advanced stage of the pressure ulcer or suspected deep tissue injury being reported?" to "What was the most advanced stage/type of the pressure injury or deep tissue pressure injury (DTPI) being reported?" -A1698 from "Stage/Category I" to "Stage 1" -A1701 from "Stage/Category II" to "Stage 2" -A1713 from "Suspected Deep Tissue Injury" to "Deep Tissue Pressure Injury (DTPI)" -A1704 from "Stage/Category III" to "Stage 3" -A1707 from "Stage/Category IV" to "Stage 4" -A1710 from "Unstageable (any type)" to "Unstageable" -A1711 from "Mucosal, arterial, or venous ulcer or diabetic foot ulcer or pressure ulcer related to palliative care" to "Mucosal pressure injury not present on admission" -Guide for Use text to replace "skin lesion" with "pressure injury".
Rationale for Change:	Data Element Name clarification, Data Element ISO Name clarification, Definition text clarification, Question text clarification, Answer value clarification, and Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Status of DTPI on admission**
Data Element ISO Name:	DTPI-Status_On admission,CD
Data Element ID:	DE411
Definition:	The status of the deep tissue pressure injury (DTPI) on admission.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What was the status on admission of the deep tissue pressure injury (DTPI)?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A1713	Deep Tissue Pressure Injury (DTPI)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1698	Stage 1	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1716	Not present	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	5
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Select "Deep Tissue Pressure Injury (DTPI)" if the most advanced stage of the pressure injury being reported was intact or non-intact skin with non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. Select "Stage 1" if the most advanced stage of the pressure injury being reported was intact skin with non-blanchable redness of a localized area usually over a bony prominence. Select "Not present" if the DTPI was not present on admission. Select "Unknown" if the status of the DTPI on admission is unknown.
References:	National Pressure Ulcer Advisory Panel http://npuap.org/resources
Collected in Module(s):	Pressure Injury
Comments:	None defined at this time.
Description of Change:	Common Format Hospital 2.0 changed the language from using the term "Pressure Ulcer" to "Pressure Injury", consistent with a change by the National Pressure Ulcer Advisory Panel (NPUAP). Removed: -A1712 "Present as suspected Deep Tissue Injury" -A1714 "Present as a Stage/Category I pressure ulcer" Added: -A1713 "Deep Tissue Pressure Injury (DTPI)" -A1698 "Stage 1" -Guide for Use text for "Deep Tissue Pressure Injury (DTPI)", "Stage 1", "Not present", and "Unknown". Changed: -Data Element Name from "sDTI status on admission" to "Status of DTPI on admission" -Data Element ISO Name from "sDTI-Status_On admission,CD" to "DTPI-Status_On admission,CD" -Definition text from "The status of the sDTI on admission." to "The status of the deep tissue pressure injury (DTPI) on admission." -Question text from "What was the status of the suspected deep tissue injury on admission?" to "What was the status on admission of the deep tissue pressure injury (DTPI)?" -Guide for Use text to replace "skin lesion" with "pressure injury".
Rationale for Change:	Data Element Name clarification, Data Element ISO Name clarification, Definition text clarification, Question text clarification, Answer value clarification, and Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Status of Stage 3, 4, or unstageable pressure injury on admission**
Data Element ISO Name:	Pressure Injury_Stage 3 4 unstageable-Status_On admission,CD
Data Element ID:	DE414
Definition:	Determination of the status of the Stage 3, 4, or unstageable pressure injury on admission.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What was the status on admission of the Stage 3, 4, or unstageable pressure injury that you are reporting?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A1716	Not present	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1698	Stage 1	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1701	Stage 2	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1713	Deep Tissue Pressure Injury (DTPI)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1704	Stage 3	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1707	Stage 4	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1710	Unstageable	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	5
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Select "Not present" if the Stage 3, 4, or unstageable pressure injury was not present on admission. Select "Stage 1" if the most advanced stage of the pressure injury being reported was intact skin with non-blanchable redness of a localized area usually over a bony prominence. Select "Stage 2" if the most advanced stage of the pressure injury being reported was partial-thickness tissue loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. Select "Deep Tissue Pressure Injury (DTPI)" if the most advanced stage of the pressure injury being reported was intact or non-intact skin with non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. Select "Stage 3" if the most advanced stage of the pressure injury being reported was full-thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Select "Stage 4" if the most advanced stage of the pressure injury being reported was full-thickness tissue loss with exposed bone, tendon or muscle. Select "Unstageable" if the most advanced stage of pressure injury being reported was full-thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed. Select "Unknown" if the status of the Stage 3, 4, or unstageable pressure injury on admission is unknown.
References:	National Pressure Ulcer Advisory Panel http://npuap.org/resources
Collected in Module(s):	Pressure Injury
Comments:	None defined at this time.
Description of Change:	Common Format Hospital 2.0 changed the language from using the term "Pressure Ulcer" to "Pressure Injury", consistent with a change by the National Pressure Ulcer Advisory Panel (NPUAP). Added: -Guide for Use text for "Not present", "Deep Tissue Pressure Injury (DTPI)", and "Unknown". Changed: -Data Element Name from "Status of Stage 3, 4, or unstageable pressure ulcer on admission" to "Status of Stage 3, 4, or unstageable pressure injury on admission"

	-Data Element ISO Name from "Pressure Ulcer-Stage3 4 unstageable-Status_On admission,CD" to "Pressure Injury-Stage 3 4 unstageable-Status_On admission,CD" -Definition text from "Determination of the status of the existing pressure ulcer on admission to the facility." to "Determination of the status of the Stage 3, 4, or unstageable pressure injury on admission." -Question text from "What was the status on admission of the Stage/Category III, IV, or unstageable pressure ulcer?" to "What was the status on admission of the Stage 3, 4, or unstageable pressure injury that you are reporting?" -A1698 from "Stage/Category I" to "Stage 1" -A1701 from "Stage/Category II" to "Stage 2" -A1713 from "Suspected Deep Tissue Injury" to "Deep Tissue Pressure Injury (DTPI)" -A1704 from "Stage/Category III" to "Stage 3" -A1707 from "Stage/Category IV" to "Stage 4" -A1710 from "Unstageable (any type)" to "Unstageable" -Guide for Use text to replace "skin lesion" with "pressure injury".
Rationale for Change:	Data Element Name clarification, Data Element ISO Name clarification, Definition text clarification, Question text clarification, Answer value clarification, and Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Admission skin inspection documented**
Data Element ISO Name:	Skin inspection-Documentation_On admission, CD
Data Element ID:	DE420
Definition:	Documentation of a skin inspection done on admission to this facility.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	On admission to this facility, was a skin inspection documented?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A15	Yes	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A18	No	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	3
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Select "Yes" if a skin inspection was documented on admission to this facility in accordance with its internal policies and procedures. Select "No" if there was no documentation of a skin inspection performed on admission in accordance with this facility's internal policies and procedures. Select "Unknown" if you do not know if a skin inspection was documented on admission to this facility.
References:	No specific reference at this time.
Collected in Module(s):	Pressure Injury
Comments:	None defined at this time.
Description of Change:	Changed: -Guide for Use text from "Select "Yes" if a skin inspection was documented on admission to the facility in accordance with its internal Policies and Procedures. Select "No" if there was no documentation of an admission skin inspection performed in accordance with the facility's internal Policies and Procedures." to "Select "Yes" if a skin inspection was documented on admission to this facility in accordance with its internal policies and procedures. Select "No" if there was no documentation of a skin inspection performed on admission in accordance with this facility's internal policies and procedures. Select "Unknown" if you do not know if a pressure injury skin assessment was documented on admission to this facility."
Rationale for Change:	Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Pressure injury prevention intervention**
Data Element ISO Name:	Prevention intervention_Pressure injury-Implementation,CD
Data Element ID:	DE432
Definition:	Determination if a pressure injury prevention intervention was implemented.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Was any pressure injury preventive intervention implemented?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A15	Yes	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A18	No	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	3
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question irrespective of whether a pressure injury risk assessment had been performed and irrespective of the results of such an assessment. Examples of pressure injury prevention interventions include repositioning, skin care practices, and pressure redistribution device(s).
References:	No specific reference at this time.
Collected in Module(s):	Pressure Injury
Comments:	None defined at this time.
Description of Change:	Common Formats Hospital 2.0 changed the language from using the term “Pressure Ulcer” to “Pressure Injury”, consistent with a change by the National Pressure Ulcer Advisory Panel (NPUAP). Changed: -Data Element Name from "Pressure ulcer prevention intervention" to "Pressure injury prevention intervention" -Data Element ISO Name from "Prevention intervention_Pressure ulcer-Implementation,CD" to "Prevention intervention_Pressure injury-Implementation,CD" -Definition text from "Determination if a prevention intervention was implemented." to "Determination if a pressure injury prevention intervention was implemented." -Question text from "Was any preventive intervention implemented?" to "Was any pressure injury preventive intervention implemented?" -Guide for Use text from "Answer this question irrespective of whether a pressure ulcer risk assessment had been performed and irrespective of the results of such an assessment. Interventions used to prevent pressure ulcers or their advancement include, among other things, the following: pressure redistribution devices, repositioning, and nutritional support." to "Answer this question irrespective of whether a pressure injury risk assessment had been performed and irrespective of the results of such an assessment. Examples of pressure injury prevention interventions include repositioning, skin care practices, and pressure redistribution device(s)."
Rationale for Change:	Data Element Name clarification, Data Element ISO Name clarification, Definition text, Question text, and Guide for Use clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Device involvement in pressure injury**
Data Element ISO Name:	Pressure injury-involved_Device,CD
Data Element ID:	DE438
Definition:	Determination whether a device, appliance, or equipment was involved in the development or advancement of the pressure injury.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Was the use of a device, appliance, or equipment involved in the development or advancement of the pressure injury?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A15	Yes	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A18	No	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	3
Multiple Choice:	No
Format:	NA
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Examples of devices, appliances, or equipment that might be involved in the development or advancement of a pressure injury include the following: anti-embolic devices; intraoperative positioning devices; orthopedic appliances (e.g., casts, splints, orthotics); oxygen delivery devices (e.g., nasal prongs, oxygen mask); restraints; tubes (e.g., endotracheal, gastrostomy, nasogastric, tracheostomy, urinary catheter).
References:	No specific reference at this time.
Collected in Module(s):	Pressure Injury
Comments:	None defined at this time.
Description of Change:	Common Formats Hospital 2.0 changed the language from using the term “Pressure Ulcer” to “Pressure Injury”, consistent with a change by the National Pressure Ulcer Advisory Panel (NPUAP). Changed: -Data Element Name from "Device involvement in pressure ulcer" to "Device involvement in pressure injury" -Data Element ISO Name from "Pressure ulcer-involved_Device,CD" to "Pressure injury-involved_Device,CD" -Definition text from "Determination whether the device or appliance was involved in the development or advancement of the pressure ulcer." to "Determination whether the device, appliance, or equipment was involved in the development or advancement of the pressure injury." -Question text from "Was the use of a device or appliance involved in the development or advancement of the pressure ulcer?" to "Was the use of a device, appliance, or equipment involved in the development or advancement of the pressure injury?" -Guide for Use text from "Examples of devices or appliances that might be involved in the development or advancement of a pressure ulcer include the following: anti-embolic devices; intraoperative positioning devices; orthopedic appliances (e.g., casts, splints, orthotics); endotracheal tubes; gastrostomy tubes; nasogastric tubes; tracheostomy tubes; and urinary catheters." to "Examples of device, appliances, or equipment that might be involved in the development or advancement of a pressure injury include the following: anti-embolic devices; intraoperative positioning devices; orthopedic appliances (e.g., casts, splints, orthotics); oxygen delivery devices (e.g., nasal prongs, oxygen mask); restraints; tubes (e.g., endotracheal, gastrostomy, nasogastric, tracheostomy, urinary catheter)."
Rationale for Change:	Data Element Name clarification, Data Element ISO Name clarification, Definition text clarification, Question text clarification, and Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Development of secondary morbidity during stay**
Data Element ISO Name:	Patient-Secondary morbidity_During patient stay,CD
Data Element ID:	DE447
Definition:	Determination if the patient developed a secondary morbidity during the stay at this facility.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	During the patient's stay at this facility, did the patient develop a secondary morbidity (e.g., osteomyelitis, sepsis, tunneling, or undermining)?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A15	Yes	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A18	No	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	3
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	No further information provided.
References:	No specific reference at this time.
Collected in Module(s):	Pressure Injury
Comments:	None defined at this time.
Description of Change:	Changed: -Question text from "During the patient's stay at this facility, did the patient develop a secondary morbidity (e.g., osteomyelitis, sepsis, tunneling, or fissure)?" to "During the patient's stay at this facility, did the patient develop a secondary morbidity (e.g., osteomyelitis, sepsis, tunneling, or undermining)?"
Rationale for Change:	Question text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Secondary morbidity attributed to pressure injury or DTPI**
Data Element ISO Name:	Pressure injury-Secondary morbidity_Attributed,CD
Data Element ID:	DE450
Definition:	Determination if the secondary morbidity attributed to the presence of the pressure injury.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Was the secondary morbidity attributed to the presence of the pressure injury?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A15	Yes	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A18	No	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	3
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	No further information provided.
References:	No specific reference at this time.
Collected in Module(s):	Pressure Injury
Comments:	None defined at this time.
Description of Change:	Common Format Hospital 2.0 changed the language from using the term "Pressure Ulcer" to "Pressure Injury", consistent with a change by the National Pressure Ulcer Advisory Panel (NPUAP). Changed: -Data Element Name from "Secondary morbidity attributed to pressure ulcer or sDTI" to "Secondary morbidity attributed to pressure injury or DTPI" -Data Element ISO Name from "Pressure ulcer-Secondary morbidity_Attributed,CD" to "Pressure injury-Secondary morbidity_Attributed,CD" -Definition text from "Determination if the secondary morbidity attributed to the presence of the pressure ulcer." to "Determination if the secondary morbidity attributed to the presence of the pressure injury." -Question text from "Was the secondary morbidity attributed to the presence of the pressure ulcer?" to "Was the secondary morbidity attributed to the presence of the pressure injury?"
Rationale for Change:	Data Element Name clarification, Data Element ISO Name clarification, Definition text clarification, and Question text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Surgery

Data Element Name:	**Physiologic complication of surgery**
Data Element ISO Name:	Surgery-Physiologic complication,CD
Data Element ID:	DE2018
Definition:	Determination if any of the following physiologic complications occurred: cardiac or circulatory event; central nervous system event; renal failure, impairment, or insufficiency; or respiratory failure.
Version:	Hospital Version 2.0
Question:	Which of the following physiologic complication(s) occurred that was not present prior to surgery?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A3054	Cardiac or circulatory event	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A3057	Central nervous system event	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A3060	Renal failure, impairment, or insufficiency	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A3063	Respiratory failure	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A66	Other: Please specify	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	5 (2000 for free text associated with "Other: Please specify" response.)
Multiple Choice:	Yes
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Select "Other: Please specify" if the physiologic complication, not present prior to surgery, is not listed in the above answer values.
References:	No specific reference at this time.
Collected in Module(s):	Surgery
Comments:	None defined at this time.
Description of Change:	N/A
Rationale for Change:	N/A
Start Date:	5/18/2017
Update Date:	N/A

Data Element Name:	**Manifestation of respiratory failure following surgery**
Data Element ISO Name:	Respiratory failure-Manifestation,CD
Data Element ID:	DE2021
Definition:	Determination of the best description of how the respiratory failure was manifested.
Version:	Hospital Version 2.0
Question:	Which of the following best describes how the respiratory failure was manifested?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A3066	Prolonged ventilator support following surgery	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A3069	Re-institution of ventilator support after discontinuance following surgery	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A3072	Use of ventilator post-operatively only	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A66	Other: Please specify	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	5 (2000 for free text associated with "Other: Please specify" response.)
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Select the answer which, in your judgement, best describes how the respiratory failure was manifested. Select A3066 "Prolonged ventilator support following surgery" refers to ventilator support that was used during the procedure and for a prolonged period of time afterward. Select A3069 “Re-institution of ventilator support after discontinuance following surgery” refers to ventilator support that, according to plan, was used during the procedure, was discontinued following the procedure, and was resumed following the discontinuance. Select A3072 “Use of ventilator post-operatively only” refers to ventilator support that was not used prior to or during the procedure, but was begun in the post-operative period. Select A66 "Other: Please specify" if the manifestation of respiratory failure is not listed in the above answer values.
References:	No specific reference at this time.
Collected in Module(s):	Surgery
Comments:	None defined at this time.
Description of Change:	N/A
Rationale for Change:	N/A
Start Date:	5/18/2017
Update Date:	N/A

Data Element Name:	**Type(s) of anesthesia and/or sedation used during surgery**
Data Element ISO Name:	Anesthesia and Sedation-Type_Combination,CD
Data Element ID:	DE2024
Definition:	Determination of the type(s) of anesthesia and/or sedation used during surgery.
Version:	Hospital Version 2.0
Question:	Which type(s) of anesthesia and/or sedation were used?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A3075	General anesthesia	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A3078	Regional anesthesia (e.g., epidural, spinal, or peripheral nerve blocks)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A3081	Local or topical anesthesia	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A3084	Sedation	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A1005	None	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	5
Multiple Choice:	Yes
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Select the type(s) of anesthesia, or sedation, that was used in association with the event. If more than one type of anesthesia was used in association with the event (e.g., local/topical anesthesia and general anesthesia), either simultaneously or sequentially, select each type of anesthesia and/or sedation used from the above answer values.
References:	No specific reference at this time.
Collected in Module(s):	Surgery
Comments:	None defined at this time.
Description of Change:	N/A
Rationale for Change:	N/A
Start Date:	5/18/2017
Update Date:	N/A

Data Element Name:	**Description of procedure associated with the event**
Data Element ISO Name:	Event_Surgery-Procedure,ED
Data Element ID:	DE461
Definition:	Brief description of the procedure associated with the event.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What was the description of the procedure associated with the event?
Value Domain:	N/A
Maximum Length:	2000
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Encapsulated Data (ED)
Guide for Use:	Describe the procedure associated with the surgical event in your own words. This information will not be submitted to the Network of Patient Safety Databases (NPSD).
References:	No specific reference at this time
Collected in Module(s):	Surgery
Comments:	None defined at this time.
Description of Change:	The "Surgery or Anesthesia" module, in Common Formats Hospital Version 1.2, has been separated into two modules, "Surgery" and "Anesthesia" in the Common Formats Hospital Version 2.0. Changed: -Question text from "Describe briefly the procedure associated with this event:" to "What was the description of the procedure associated with the event?" -Guide for Use text from "Answer the questions for Surgery or Anesthesia only if (1) the patient safety concern involved an event, i.e., an incident or a near miss, and (2) the event involved a surgical or other invasive procedure or the administration of anesthesia, including immediate preparations for same, e.g., a crash intubation. Describe the procedure associated with the event in your own words. If the event did not involve an invasive procedure, but only the administration of anesthesia, e.g., anesthesia for a non-invasive orthopedic manipulation, indicate the reason for the anesthetic and/or the type of associated non-invasive procedure, if any. This information will not be forwarded to the Network of Patient Safety Databases (NPSD)." to "Describe the procedure associated with the surgical event in your own words. This information will not be submitted to the Network of Patient Safety Databases (NPSD)."
Rationale for Change:	Question text clarification and Guide for Use text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Characteristics of surgical event**
Data Element ISO Name:	Event_Surgery-Characteristic,CD
Data Element ID:	DE513
Definition:	Determination of the best characterization of the surgical event from the list provided.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Which of the following best characterizes the surgical event?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A2172	Surgical site infection	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2175	Bleeding requiring return to the operating room	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2178	Burn and/or operating room fire	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2179	Retained surgical item	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2181	Incorrect surgical or invasive procedure	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2184	Iatrogenic pneumothorax	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2187	Unintended laceration or puncture	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2190	Dehiscence, flap or wound failure or disruption, or graft failure	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2193	Unintended blockage, obstruction, or ligation	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2196	Unplanned removal of organ	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2199	Air embolus	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2200	Physiologic complication not present prior to surgery	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A66	Other: Please specify	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	5 (2000 for free text associated with "Other: Please specify" response.)
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	If more than one listed response applies, select the one that best characterizes the surgical event. Select "Other: Please specify" if the type of surgical event that occurred is not listed in the above answer values, and describe the event.
References:	No specific reference at this time.
Collected in Module(s):	Surgery
Comments:	None defined at this time.
Description of Change:	The "Surgery or Anesthesia" module, in Common Formats Hospital Version 1.2, has been separated into two modules, "Surgery" and "Anesthesia" in the Common Formats Hospital Version 2.0. Added: -A2179 "Retained surgical item"

	-A2200 "Physiologic complication not present prior to surgery" Changed: -Data Element Name from "Characteristics of surgical adverse outcome" to "Characteristics of surgical event" -Data Element ISO Name from "Adverse outcome_Surgery-Characteristic,CD" to "Event_Surgery-Characteristic,CD" -Guide for Use text from "Answer this question only if the event is best described as a 'Surgical event.' If more than one listed response applies, select the one that best characterizes the surgical event. If none of the listed responses apply, select 'Other' and provide your own characterization." to "If more than one listed response applies, select the one that best characterizes the surgical event. Select "Other: Please specify" if the type of surgical event that occurred is not listed in the above answer values, and describe the event."
Rationale for Change:	Data Element Name clarification, Data Element ISO Name clarification, Guide for Use text clarification, and Answer value clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Occurrence of burn and/or operating room fire**
Data Element ISO Name:	Event_Surgery-Burn and/or operating room fire,CD
Data Element ID:	DE516
Definition:	Determination of whether the surgical event was a burn, operating room fire, or both.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	Was the surgical event a burn, operating room fire, or both?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A2205	Burn	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2208	Operating room fire	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2211	Both	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	5
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	No further information provided.
References:	No specific reference at this time.
Collected in Module(s):	Surgery
Comments:	None defined at this time.
Description of Change:	The "Surgery or Anesthesia" module, in Common Formats Hospital Version 1.2, has been separated into two modules, "Surgery" and "Anesthesia" in the Common Formats Hospital Version 2.0. Changed: -Data Element ISO Name from "Adverse outcome_Surgery-Burn and/or operating room fire,CD" to "Event_Surgery-Burn and/or operating room fire,CD" -Definition from "Determination of whether the surgical adverse outcome was a burn, operating room fire or both." to "Determination of whether the surgical event was a burn, operating room fire, or both." -Question text from "Which of the following occurred?" to "Was the surgical event a burn, operating room fire, or both?"
Rationale for Change:	Data Element ISO Name clarification, Definition text clarification, and Question text clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Data Element Name:	**Incorrect surgical or invasive procedure**
Data Element ISO Name:	Incorrect surgical or invasive procedure-Surgery,CD
Data Element ID:	DE519
Definition:	Determination of what was incorrect about the surgical or invasive procedure.
Version:	Hospital Version 1.1; Hospital Version 1.2; Hospital Version 2.0
Question:	What was incorrect about the surgical or invasive procedure?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A585	Incorrect patient	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2217	Incorrect side	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2220	Incorrect site	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2223	Incorrect procedure	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2224	Incorrect implant	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	5
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only if the best characterization of the surgical event is "Incorrect surgical or invasive procedure." If more than one of the listed choices applies to the event, select only the most serious event of the above answer values.
References:	No specific reference at this time.
Collected in Module(s):	Surgery
Comments:	None defined at this time.
Description of Change:	The "Surgery or Anesthesia" module, in Common Formats Hospital Version 1.2, has been separated into two modules, "Surgery" and "Anesthesia" in the Common Formats Hospital Version 2.0. Removed: -A2229 "Incorrect implant because correct implant was not available" -A2226 "Incorrect implant by mistake" -A66 "Other: Please specify" Added: -A2224 "Incorrect implant" Changed: -Data Element Name from "Incorrect action for surgical or invasive procedure" to "Incorrect surgical or invasive procedure" -Data Element ISO Name from "Incorrect action-Surgery,CD" to "Incorrect surgical or invasive procedure-Surgery,CD" -Guide for Use text from "Answer this question only if the best characterization of the surgical adverse outcome is 'Incorrect or invasive procedure. 'If more than one of the listed choices applies to the event, select the first such choice that applies. Do not select 'Other' unless none of the listed choices apply." to "Answer this question only if the best characterization of the surgical event is "Incorrect surgical or invasive procedure." If more than one of the listed choices applies to the event, select only the most serious event of the above answer values."
Rationale for Change:	Data Element Name clarification, Data Element ISO Name clarification, Guide for Use clarification, and Answer value clarification.
Start Date:	3/31/2010
Update Date:	5/18/2017

Venous Thromboembolism

Data Element Name:	**VTE type(s)**
Data Element ISO Name:	VTE-type,CD
Data Element ID:	DE1003
Definition:	Determination of the type(s) of venous thromboembolism.
Version:	Hospital Version 1.2; Hospital Version 2.0
Question:	Which of the following occurred?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A2601	Deep Vein Thrombosis (DVT)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2604	Pulmonary Embolism (PE)	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	5
Multiple Choice:	Yes
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	A venous thromboembolism (VTE) event comprises an objectively confirmed symptomatic deep vein thrombosis (DVT) and/or pulmonary embolism (PE). DVT refers to partial or total thrombotic occlusion of a deep vein of the lower extremity or pelvis (e.g., inferior vena cava, iliac, femoral, popliteal, tibial, gastrocnemial, soleal, or peroneal vein) or a deep vein of the upper extremity or upper thorax (e.g., internal jugular, brachiocephalic, superior vena cava, axillary, brachial, or subclavian). Symptomatic DVT is an objectively confirmed DVT that results in symptoms that include pain and/or swelling of the affected limb. PE refers to a partial or total thromboembolic occlusion of one or more pulmonary arteries that causes symptoms or death. Symptomatic PE is an objectively confirmed PE that results in symptoms or signs such as shortness of breath, pleuritic chest pain, hemoptysis, oxygen desaturation, or death. PE does not include non-thrombotic emboli (e.g., air, fat, amniotic fluid, or foreign body or material). Reported VTEs are not intended to include: -DVT present on admission -PE present on admission -DVT or PE in a patient documented to be receiving comfort care
References:	No specific reference at this time.
Collected in Module(s):	Venous Thromboembolism
Comments:	None defined at this time.
Description of Change:	Removed: -Guide for Use text describing prior reporting exclusions. Changed: -Guide for Use text from "This question and what follows are used to report a deep vein thrombosis (DVT) or a pulmonary embolism (PE) or both that (1) had onset during this stay; (2) was/were present on admission but occurred or developed within 30 days of a prior discharge from this facility; or (3) had onset within 30 days of discharge from this facility." to "A venous thromboembolism (VTE) event comprises an objectively confirmed symptomatic deep vein thrombosis (DVT) and/or pulmonary embolism (PE). DVT refers to partial or total thrombotic occlusion of a deep vein of the lower extremity or pelvis (e.g., inferior vena cava, iliac, femoral, popliteal, tibial, gastrocnemial, soleal, or peroneal vein) or a deep vein of the upper extremity or upper thorax (e.g., internal jugular, brachiocephalic, superior vena cava, axillary, brachial, or subclavian). Symptomatic DVT is an objectively confirmed DVT that results in symptoms that include pain and/or swelling of the affected limb. PE refers to a partial or total thromboembolic occlusion of one or more pulmonary arteries that causes symptoms or death. Symptomatic PE is an objectively confirmed PE that results in symptoms or signs such as shortness of breath, pleuritic chest pain,

	hemoptysis, oxygen desaturation, or death. PE does not include non-thrombotic emboli (e.g., air, fat, amniotic fluid, or foreign body or material). Reported VTEs are not intended to include: -DVT present on admission -PE present on admission -DVT or PE in a patient documented to be receiving comfort care"
Rationale for Change:	Guide for Use text clarification.
Start Date:	4/3/2012
Update Date:	5/18/2017

Data Element Name:	**DVT location**
Data Element ISO Name:	DVT-location,CD
Data Element ID:	DE1006
Definition:	Determination of the location of the Deep Vein Thrombosis (DVT).
Version:	Hospital Version 1.2; Hospital Version 2.0
Question:	What was the location of the Deep Vein Thrombosis (DVT)?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A2607	Upper extremity/upper thorax	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2610	Lower extremity/pelvis	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A2211	Both	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats

Maximum Length:	5
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	The location of the Deep Vein Thrombosis (DVT) may be most easily found in the report of a confirmatory imaging study.
References:	No specific reference at this time.
Collected in Module(s):	Venous Thromboembolism
Comments:	None defined at this time.
Description of Change:	N/A
Rationale for Change:	N/A
Start Date:	4/3/2012
Update Date:	N/A

Data Element Name:	**VTE prior risk assessment**
Data Element ISO Name:	Risk assessment-Documentation_Prior to VTE,CD
Data Element ID:	DE1015
Definition:	Determination if a VTE risk assessment was documented prior to the onset of the VTE.
Version:	Hospital Version 1.2; Hospital Version 2.0
Question:	Prior to the onset of the VTE event, was a VTE risk assessment documented?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A15	Yes	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A18	No	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	3
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	The following publications contain more information on prophylaxis of VTE and risk assessments: Qaseem A, Chou R, Humphrey L, Stanley M, Shekelle P. Venous Thromboembolism Prophylaxis in Hospitalized Patients: A Clinical Practice Guideline from the American College of Physicians. Ann Int Med. 2011;155:625-632 Guyatt G, Akl E, Crowther M, Gutterman D, Schuunemann H,and for the American College of Chest Physicians Antithrombotic Therapy and Prevention of Thrombosis Panel. Executive Summary: Antithrombotic Therapy and Prevention of Thrombosis, 9th ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines. Chest 2012;141:2 suppl 7S-47S
References:	No specific reference at this time.
Collected in Module(s):	Venous Thromboembolism
Comments:	None defined at this time.
Description of Change:	Removed: -Guide for Use text "If the facility uses a formal VTE risk assessment, e.g., an assessment that yields a numerical risk score, indicate whether the results of such an assessment were documented in the medical record prior to the onset of the VTE incident." Changed: -Definition text from "Determination if a formal VTE risk assessment was documented prior to the onset of the VTE." to "Determination if a VTE risk assessment was documented prior to the onset of the VTE." -Guide for Use text from "The following recent publications contain more information on prophylaxis of VTE and risk assessments" to "The following publications contain more information on prophylaxis of VTE and risk assessments." -Question text from "Prior to the onset of the VTE incident, was a formal VTE risk assessment documented?" to "Prior to the onset of the VTE event, was a VTE risk assessment documented?"
Rationale for Change:	Definition text clarification, Question text clarification, and Guide for Use text clarification.
Start Date:	4/3/2012
Update Date:	5/18/2017

Data Element Name:	**VTE physical/mechanical prophylaxis**
Data Element ISO Name:	VTE_Prophylaxis-Physical/mechanical_Application,CD
Data Element ID:	DE1027
Definition:	Determination if any physical or mechanical prophylaxis was applied prior to the onset of the VTE.
Version:	Hospital Version 1.2; Hospital Version 2.0
Question:	Prior to the onset of the VTE event, was any physical or mechanical prophylaxis (e.g., graduated compression stockings, intermittent pneumatic compression device, venous foot pumps) applied?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A15	Yes	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A18	No	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	3
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only with respect to physical or mechanical VTE prophylaxis. Pharmacologic VTE prophylaxis is addressed in DE1030. Select 'Yes" if prophylaxis was applied. Select "No" if prophylaxis was not applied. Select "Unknown" if you do not know if prophylaxis was applied.
References:	No specific reference at this time.
Collected in Module(s):	Venous Thromboembolism
Comments:	None defined at this time.
Description of Change:	Changed: -Guide for Use text from "Answer this question only with respect to mechanical VTE prophylaxis. Pharmacologic VTE prophylaxis is addressed elsewhere in these Common Formats." to "Answer this question only with respect to physical or mechanical VTE prophylaxis. Pharmacologic VTE prophylaxis is addressed in DE1030. Select 'Yes" if prophylaxis was applied. Select "No" if prophylaxis was not applied. Select "Unknown" if you do not know if prophylaxis was applied." -Question text from "Prior to the onset of the VTE incident, was any physical or mechanical prophylaxis (e.g., graduated compression stockings, intermittent pneumatic compression device, venous foot pumps) applied?" to "Prior to the onset of the VTE event, was any physical or mechanical prophylaxis (e.g., graduated compression stockings, intermittent pneumatic compression device, venous foot pumps) applied?"
Rationale for Change:	Guide for Use text clarification and Question text clarification.
Start Date:	4/3/2012
Update Date:	5/18/2017

Data Element Name:	**VTE pharmacological prophylaxis**
Data Element ISO Name:	VTE_Prophylaxis-Pharmacological anticoagulant_Administration,CD
Data Element ID:	DE1030
Definition:	Determination if any pharmacological anticoagulant prophylaxis was administered prior to the onset of the VTE.
Version:	Hospital Version 1.2; Hospital Version 2.0
Question:	Prior to the onset of the VTE event, was any pharmacological anticoagulant prophylaxis administered?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A15	Yes	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A18	No	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	3
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Answer this question only with respect to pharmacologic anticoagulant VTE prophylaxis. Mechanical VTE prophylaxis is addressed in DE1027. Pharmacologic VTE prophylaxis includes enoxaparin, heparin, fondaparinux, and coumadin (Warfarin). Select "Yes" if pharmacologic anticoagulant prophylaxis was given. Select "No" if pharmacologic anticoagulant prophylaxis was not given. Select "Unknown" if you do not know if pharmacologic anticoagulant prophylaxis was given.
References:	No specific reference at this time.
Collected in Module(s):	Venous Thromboembolism
Comments:	None defined at this time.
Description of Change:	Changed: -Guide for Use text from "Answer this question only with respect to pharmacologic VTE prophylaxis. Mechanical VTE prophylaxis is addressed elsewhere in these Common Formats. Pharmacologic VTE prophylaxis includes enoxaparin, heparin, fondaparinux, and Coumadin (Warfarin)." to "Answer this question only with respect to pharmacologic anticoagulant VTE prophylaxis. Mechanical VTE prophylaxis is addressed in DE1027. Pharmacologic VTE prophylaxis includes enoxaparin, heparin, fondaparinux, and coumadin (Warfarin). Select "Yes" if pharmacologic anticoagulant prophylaxis was given. Select "No" if pharmacologic anticoagulant prophylaxis was not given. Select "Unknown" if you do not know if pharmacologic anticoagulant prophylaxis was given." -Question text from "Prior to onset of the VTE incident, was any pharmacological anticoagulant prophylaxis administered?" to "Prior to the onset of the VTE event, was any pharmacological anticoagulant prophylaxis administered?"
Rationale for Change:	Guide for Use text clarification and Question text clarification.
Start Date:	4/3/2012
Update Date:	5/18/2017

Data Element Name:	**Presence of intravenous catheter**
Data Element ISO Name:	IV Catheter_Location of DVT,CD
Data Element ID:	DE2027
Definition:	Presence of an intravenous (IV) catheter at site of Deep Vein Thrombosis (DVT).
Version:	Hospital Version 2.0
Question:	Was an intravenous (IV) catheter present at the site of the Deep Vein Thrombosis (DVT)?

Value Domain:

Answer Code	Answer Value	Code System	Code System Name
A15	Yes	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
A18	No	2.16.840.1.113883.3.263.1.12	AHRQ Common Formats
UNK	Unknown	2.16.840.1.113883.5.1008	HL7 NullFlavor

Maximum Length:	3
Multiple Choice:	No
Format:	N/A
Data Type:	Character
HL7 Data Type:	Concept Descriptor (CD)
Guide for Use:	Select "Yes" if an IV catheter was present at the site of DVT. Select "No" if an IV catheter was not present at the site of DVT. Select "Unknown" if you do not know if an IV catheter was present at the site of DVT.
References:	No specific reference at this time.
Collected in Module(s):	Venous Thromboembolism
Comments:	None defined at this time.
Description of Change:	N/A
Rationale for Change:	N/A
Start Date:	5/18/2017
Update Date:	N/A