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PA-PSRS Automated Data Interface XML Specifications

Part 3 of 3 – Appendix



Pennsylvania Patient Safety Reporting System

Supports Schema Version 6.5

November 17, 2015

All information provided regarding the PA-PSRS data interface specifications, which information includes but is not limited to information regarding the data structure and processing logic of the PA-PSRS system, is owned exclusively by the Pennsylvania Patient Safety Authority. This information may be used only in connection with, and solely for the purpose of, the development of an interface between the PA-PSRS system and an internal reporting system at a medical facility that is: 1) physically located in the Commonwealth of Pennsylvania and, 2) subject to the reporting requirements of Act 13.

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Document History

Version	Author / Date Last Updated	Description of Change
6.0	EDS – March 1, 2006	Original Document
6.1	EDS – May 26, 2006	Updated Appendix N to include new error codes
6.2	EDS – August 21, 2006	Modified version number to match additional documents (part 1, part 2).
6.3	EDS – August 14, 2007	Updated error description for error code ' R-MED031-W '
6.4	EDS – September 19, 2007	<ul style="list-style-type: none"> Updated level 6 under Medication Error to read 'includes contraindicated drugs' (page 2) Correcting spelling error 'fracture' (page 22)
6.5	EDS – January 3, 2008	<p>Changed Code 6.6 "Nosocomial infection" to "Healthcare-associated infection"</p> <p>Changed Code 6.6.3 "Nosocomial pneumonia" to "Healthcare-associated pneumonia"</p> <p>Changed Code 6.6.8 "Other nosocomial infection (specify)" to "Other healthcare-associated infection (Specify)"</p>
6.6	EDS – June 8, 2008	Added two new skin integrity stages (0 and 5) to Appendix M (page 23)
Supports Schema 6.5	HP – January 12, 2015	<p>Modified the PA-PSRS taxonomy to incorporate the PA-PSRS standardization release changes. The changes are highlighted in yellow.</p> <p>Updated the document version to reflect the latest schema version that is being supported. (Schema 6.5)</p> <p>Corrected typographical error (Event Type 5 – Sub Category 1-1 Sub Category 2-18 (Wrong side (L vs. R)</p> <p>Added new error codes related the new HealthIT question and follow up questions.</p> <p>Added missing error code for previously added patient status question.</p>
Supports Schema 6.5	HP – 5/6/2015	Removed Other / Death or Injury involving seclusion. This event type and sub category are only accepted in PA-PSRS as a serious event, therefore not accepted through the interface..
Supports Schema 6.5	HP – 11/17/2015	Removed Other / Death or Injury involving restraints. This event type and sub category are only accepted in PA-PSRS as a serious event, therefore not accepted through the interface..

Appendix A – Conformance Definition

Keyword	Description
MUST	This word, or the terms "REQUIRED" or "SHALL", mean that the definition is an absolute requirement of the specification.
MUST NOT	This phrase, or the phrase "SHALL NOT", means that the definition is an absolute prohibition of the specification.
SHOULD	This word, or the adjective "RECOMMENDED", mean that there may exist valid reasons in particular circumstances to ignore a particular item, but the full implications must be understood and carefully weighed before choosing a different course.
SHOULD NOT	This phrase, or the phrase "NOT RECOMMENDED" mean that there may exist valid reasons in particular circumstances when the particular behavior is acceptable or even useful, but the full implications should be understood and the case carefully weighed before implementing any behavior described with this label.
MAY	This word, or the adjective "OPTIONAL", means that an item is truly optional. One vendor may choose to include the item because a particular marketplace requires it or because the vendor feels that it enhances the product while another vendor may omit the same item. An implementation which does not include a particular option MUST be prepared to interoperate with another implementation which does include the option, though perhaps with reduced functionality. In the same vein an implementation which does include a particular option MUST be prepared to interoperate with another implementation which does not include the option (except, of course, for the feature the option provides.)

Acknowledgments:

The definitions of these terms are an amalgam of definitions taken from RFC 2119: Key words for use in RFCs to Indicate Requirement Levels , S. Bradner, 1997.

Appendix B – Event Type Description

Incident / Serious Event Reports:

Level 1 Code	Level 1 Description	Level 2 Code	Level 2 Description	Level 3 Code	Level 3 Description
1	Medication Error				
		1	Dose Omission		
		2	Extra dose		
		3	Wrong		
				1	Dose / over dosage
				2	Dose / under dosage
				3	Drug
				4	Dosage form
				5	Duration
				6	Rate (IV)
				7	Route
				8	Strength / concentration
				9	Technique
				10	Time
				11	Patient
		4	Prescription / refill delayed		
		5	Medication list incorrect		
		6	Monitoring error (includes contraindicated drugs)		
				1	Drug-drug interaction
				2	Drug-food / nutrient interaction
				3	Documented allergy
				4	Drug-disease interaction

Level 1 Code	Level 1 Description	Level 2 Code	Level 2 Description	Level 3 Code	Level 3 Description
				5	Clinical (lab value, vital sign)
				6	Deteriorated drug / biologic
				7	Contaminated drug / biologic
				8	Other (specify)
		7	Unauthorized drug		
		8	Inadequate pain management		
		9	Other (specify)		
2	Adverse Drug Reaction (not a medication error)				
		1	Skin reaction (rash, blistering, itching, hives)		
		2	Hypotension		
		3	Arrhythmia		
		4	Hematologic problem		
		5	Nephrotoxicity		
		6	Dizziness		
		7	Mental status change		
		8	Other (specify)		
3	Equipment / Supplies / Devices				
		1	Disconnected		
		2	Electrical problem		
		3	Equipment not available		
		4	Equipment malfunction		
		5	Equipment wrong or inadequate		
		6	Equipment misuse		
		7	Inadequate supplies		
		8	Medical device problem		

Level 1 Code	Level 1 Description	Level 2 Code	Level 2 Description	Level 3 Code	Level 3 Description
		9	Equipment safety situation		
				1	Preventive maintenance inadequate / not performed
				2	Failed test of standard procedures
				3	Other (specify)
		10	Other (specify)		
		11	Broken item(s)		
		12	Outdated item(s)		
		13	Sterilization problem		
4	Fall				
		1	Lying in bed		
		2	Assisted fall		
		3	Sitting at side of bed		
		4	Sitting in chair / wheelchair		
		5	Transferring		
		6	Ambulating		
		7	Toileting		
		8	In Exam Room / from exam table		
		9	Hallways of facility		
		10	Grounds of facility		
		11	Other / Unknown (specify)		
		12	From stretcher		
		13	Found on floor		
5	Error related to Procedure / Treatment / Test				
		1	Surgery / invasive procedure problem		

Level 1 Code	Level 1 Description	Level 2 Code	Level 2 Description	Level 3 Code	Level 3 Description
				1	Break in sterile technique
				2	Consent missing / inadequate
				3	Count incomplete / not performed
				4	Count incorrect - Needles
				5	Count incorrect - Sponges
				6	Count incorrect - Equipment
				7	Foreign body in patient
				8	Preparation inadequate / wrong
				9	Procedure not ordered
				10	Procedure cancelled or not performed
				11	Procedure delayed
				12	Procedure not completed
				13	Unintended laceration or puncture
				14	Wrong procedure
				15	Wrong patient
				16	ID missing / incorrect
				17	Wrong site
				18	Wrong side (L vs. R)
				19	Other (specify)
				1	Test not ordered
				2	Test ordered, not performed
				3	Wrong test ordered
				4	Wrong test performed
				5	Wrong patient

Level 1 Code	Level 1 Description	Level 2 Code	Level 2 Description	Level 3 Code	Level 3 Description		
				6	Wrong result		
				7	Result missing or delayed		
				8	Specimen quality problem		
				9	Specimen delivery problem		
				10	Mislabeled specimen		
				11	Specimen label incomplete / missing		
				12	Other (specify)		
		3	Radiology / imaging test problem				
						1	Not ordered
						2	Ordered, not performed
						3	Delay in scheduling
						4	Not completed
						5	Report unavailable / delayed
						6	Incorrect reading
						7	Film unavailable or inadequate
						8	Unanticipated radiation exposure
						9	MRI safety violation
						10	Wrong procedure
						11	Wrong patient
						12	Wrong site
						13	Wrong side (L vs. R)
14	Other (specify)						
4	Referral / consult problem						
				1	Delay in scheduling		
				2	Delay in service		

Level 1 Code	Level 1 Description	Level 2 Code	Level 2 Description	Level 3 Code	Level 3 Description
				3	Report unavailable / delayed
				4	Other (specify)
		5	Respiratory care		
				1	Self / unplanned extubation
				2	Unplanned / emergent intubation following a procedure / treatment / test
				3	Ventilator alarms not set properly
				4	Ventilator alarms inaudible
				5	Ventilator settings wrong / changed without authorization
				6	Missed treatment
				7	Medical gas problem
				8	Other
		6	Other (specify)		
		7	Dietary		
				1	Incorrect diet
				2	Patient allergy to diet
				3	NPO patient given food
				4	Foreign body in food
				5	Other dietary issues (specify)
6	Complication of Procedure / Treatment / Test				
		1	Complication following surgery or invasive procedure		
				1	Death
				2	Cardiopulmonary arrest
				3	Myocardial infarction
				4	Unplanned transfer to ICU

Level 1 Code	Level 1 Description	Level 2 Code	Level 2 Description	Level 3 Code	Level 3 Description
				5	Unplanned return to Operating Room
				6	Removal of tube or other medical device by patient
				7	Wound dehiscence
				8	Acute renal failure
				9	Stroke or other neurologic deficit
				10	Deep venous thrombosis
				11	Pulmonary embolism
				12	Intravascular air embolism
				13	Pneumothorax
				14	Other (specify)
		2	Anesthesia Event		
				1	Death
				2	Cardiopulmonary arrest
				3	Myocardial Infarction
				4	Stroke
				5	Aspiration
				6	Intubation trauma
				7	Use of reversal agents
				8	Other (specify)
		3	Emergency Department		
				1	Unplanned return to ED in 48 hrs requiring admission
				2	Discrepancy between ED interpretation of X-ray or EKG and final reading
				5	Other (specify)
		4	Maternal complication		

Level 1 Code	Level 1 Description	Level 2 Code	Level 2 Description	Level 3 Code	Level 3 Description		
				1	Death		
				2	Unplanned transfer to ICU		
				3	Intrapartum fetal death		
				4	Uterine rupture		
				5	Unanticipated blood transfusion		
				6	DVT (Deep Venous Thrombosis)		
				7	PE (Pulmonary Embolism)		
				8	Seizure		
				9	Infection		
				10	Other (specify)		
		5	Neonatal complication				
						1	Neonatal death
						2	Unplanned transfer to NICU
						3	Apgar < 5 at 5 min
						4	Birth injury or trauma
						5	Undiagnosed or untreated hyperbilirubinemia
						6	Other (specify)
		6	Healthcare-associated Infection				
						1	Intravascular catheter infection
						2	Wound or surgical site infection
						3	Healthcare-associated pneumonia
						4	Sepsis 48 hrs post admit
						5	Antibiotic-associated diarrhea
						6	Antibiotic resistant organism
						7	Urinary tract infection

Level 1 Code	Level 1 Description	Level 2 Code	Level 2 Description	Level 3 Code	Level 3 Description
				8	Other healthcare-associated infection (specify)
		7	Cardiopulmonary arrest outside of ICU setting		
		8	IV site complication (phlebitis, bruising, infiltration)		
		9	Extravasation of drug or radiologic contrast		
		10	Catheter or tube problem		
		11	Onset of hypoglycemia during care		
		12	Complication following spinal manipulative therapy		
		13	Other (specify)		
7	Transfusion				
		1	Apparent transfusion reaction		
		2	Event related to blood product administration		
		3	Event related to blood product dispensing or distribution		
		4	Event related to blood product sample collection		
		5	Mismatched unit		
		6	Wrong component requested		
		7	Wrong component issued		
		8	Wrong patient requested		
		9	Wrong patient transfused		
		10	Special product need not requested		
		11	Special product need not issued		
		12	Other (specify)		
		13	Consent missing / inadequate		
8	Skin Integrity				
		1	Pressure ulcer		
				1	Admitted from other facility with ulcer

Level 1 Code	Level 1 Description	Level 2 Code	Level 2 Description	Level 3 Code	Level 3 Description	
				2	New ulcer < 24 hours after admission	
				3	New ulcer > 24 hours after admission	
		2	Venous stasis ulcer			
		3	Burn (electrical, chemical, thermal)			
		4	Rash / hives			
		5	Abrasion			
		6	Laceration			
		7	Blister			
		8	Other (specify)			
9	Skin tear					
9	Other / Miscellaneous					
		1	Inappropriate discharge			
		2	Other unexpected death			
		3	Electric shock to patient			
		5	Other (specify)			
		7	Unanticipated transfer to higher level of care			
				1	Intra-facility transfer to higher acuity unit	
				2	Inter-facility transfer to higher acuity facility/unit	
		3	Other unanticipated transfer			
10	Patient Self Harm					
		3	Self-mutilation			
		4	Ingestion of foreign object or substance			
		5	Anorexia/bulimia			
		6	Other self-harm (specify)			

Appendix C – Harm Score Description

Submission Type	Code	Description
Incident	A	Circumstances that could cause adverse events (e.g., look-alike medications, confusing equipment, etc.).
	B1	An event occurred but it did not reach the individual (“near miss” or “close call”) because of chance alone.
	B2	An event occurred but it did not reach the individual (“near miss” or “close call”) because of active recovery efforts by caregivers.
	C	An event occurred that reached the individual but did not cause harm and did not require increased monitoring (an error of omission such as a missed medication dose does reach the individual).
	D	An event occurred that required monitoring to confirm that it resulted in no harm and/or required intervention to prevent harm.

Appendix D – Likelihood of Event Recurrence

Code	Description
1	Frequent
2	Occasional
3	Uncommon
4	Remote

Appendix E – Severity of Effect

Code	Description
1	Catastrophic
2	Major
3	Moderate
4	Minor

Appendix F – List of Root Causes

Code	Description
2	Behavioral assessment process
3	Physical assessment process
4	Patient identification process
5	Patient observation procedures
6	Care planning process
7	Staffing levels
8	Orientation & training of staff
9	Competency assessment / credentialing
10	Supervision of staff
11	Communication with patient/family
12	Communication among staff members
13	Availability of information
14	Adequacy of technological support
15	Equipment maintenance / management
16	Physical environment
17	Security systems and processes
18	Control of medications: storage/access
19	Labeling of medications
20	Other

Appendix G – Eindhoven Root Cause Analysis Categories

Code	Description
1	Technical factor: External (T-EX)
2	Technical factor: Design (TD)
3	Technical factor: Construction (TC)
4	Organizational factor: External (O-Ex)
5	Technical factor: Materials (TM)
6	Organizational factor: Knowledge transfer (OK)
7	Organizational factor: Protocols (OP)
8	Organizational factor: Management priorities (OM)
9	Organizational factor: Culture (OC)
10	Human behavior: External (H-Ex)
11	Human behavior: Knowledge based (HKK)
12	Human behavior: Rules based – Qualifications (HRQ)
13	Human behavior: Rules based – Coordination (HRC)
14	Human behavior: Rules based – Verification (HRV)
15	Human behavior: Rules based – Intervention (HRI)
16	Human behavior: Rules based – Monitoring (HRM)
17	Human behavior: Skills based – Slip (HSS)
18	Human behavior: Skills based – Tripping (HST)
19	Patient related factor (PRF)
20	Unclassifiable (X)

Appendix H – Medication Route Code

Code	Description
1	Ear
2	Epidural
3	Eye
4	Intramuscular (IM)
5	IV Continuous
6	IV Piggyback
7	IV Push
8	Patient-Controlled Analgesia (PCA)
9	Oral (PO)
10	Rectal (PR)
11	Subcutaneous (SC)
12	Sublingual (SL)
13	Transdermal
14	Other
15	Topical
16	Vaginal

Appendix I – High Alert Medication Codes

Code	High Alert Medication Description
1	IV adrenergic agonists (e.g., epinephrine)
2	Benzodiazepine
3	Chemotherapeutic agent
4	IV inotropic medications (e.g., digoxin, milrinone)
5	Chloral hydrate
6	Neuromuscular blocking agents
7	IV unfractionated heparin
8	Insulin
9	Oral hypoglycemics
10	Lidocaine, local anesthetics in large vials
11	IV Magnesium Sulfate
12	Hypertonic sodium chloride(Sodium Chloride greater than 0.9% concentration)
13	IV Calcium
14	IV Potassium
15	IV Theophylline
16	IV thrombolytics/fibrinolytics (e.g., tenectepase)
17	Opiates/Narcotics
18	Warfarin
19	IV adrenergic antagonists (e.g., propranolol)
20	General anesthetic agents, inhaled and IV (e.g., propofol)
21	Cardioplegic solutions
22	Hypertonic dextrose (dextrose greater than or equal to 20%)
23	Dialysis solutions
24	Epidural or intrathecal medications
25	Glycoprotein IIb/IIIa inhibitors (e.g., eptifibatide)

Code	High Alert Medication Description
26	Liposomal forms of drugs (e.g., liposomal amphotericin B)
27	IV moderate sedation agents (e.g., midazolam)
28	IV radiocontrast agents
29	Total parenteral nutrition solutions
30	IV amiodarone
31	Colchicine injection
32	Low molecular weight heparin injection
33	Oral methotrexate, non-oncologic use
34	Nesiritide
35	Nitroprusside sodium for injection

Appendix J – ADR Analysis Causal Relationship Codes

Code	Description
1	Highly probable: Follows a reasonable temporal relationship and is suggested by drug withdrawal and rechallenge
2	Probable: Follows a reasonable temporal relationship, is suggested by drug withdrawal and cannot be explained by patient's clinical state
3	Possible: Follows a temporal relationship but has not been confirmed by drug withdrawal and may be explained by patient's clinical state
4	Doubtful: No apparent temporal relationship
5	To be determined

Appendix K – ADR Analysis Severity Index Codes

Code	Description
1	Mild reaction requiring no treatment
2	ADR led to discontinuation of suspected drug; no further treatment required
3	Serious ADR, but benefits of drug outweigh intensity of ADR, so drug is continued
4	ADR requires additional medications, treatment or dosage reduction, but it does not pose a grave risk to the patient
5	Serious ADR that is potentially life-threatening or puts the patient at serious risk
6	Death of the patient is directly related to ADR
7	To be determined

Appendix L – Fall Level of Injury

Code	Description
1	No injury
2	Minor - resulted in application of a dressing, ice, cleaning of a wound, limb elevation, or topical medication
3	Moderate - resulted in suturing, steri-strips, fracture, or splinting
4	Major - resulted in surgery, casting, or traction
5	Death - the patient died as a result of the fall

Appendix M – Stage Skin Integrity

Code	Description
0	Suspected Deep Tissue Injury: A localized area of discolored (purple or maroon) intact skin or blood filled blister. The area may be painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
1	Stage I: A reddened area on the skin that, when pressed, is "non-blanchable" (does not turn white). This indicates that a pressure ulcer is starting to develop.
2	Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated.
3	Stage III: The skin breakdown now looks like a crater where there is damage to the tissue below the skin.
4	Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes tendons and joints.
5	Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

Appendix N – Error Codes and Messages

Code	Description
V-BAT001-F	A fatal error prevented this Batch from being processed.
V-BAT002-W	Invalid or missing schema version
R-BAT010-F	PA-PSRS currently does not support the mode value submitted.
V-BAT010-F	Invalid mode element value.
V-BAT020-F	Invalid facility identifier value.
R-BAT040-W	The number of reports element value does not match the actual number of reports contained in the batch.
V-BAT040-F	Invalid value for number of reports in batch.
V-BAT050-F	Invalid or missing batch number.
V-BAT051-W	Batch numbers were out of sequence.
V-BAT060-F	Batch file name is not in the correct format.
V-BAT070-F	The Batch Number submitted does not match the Batch Number contained in the file name.
V-BAT080-F	FTP Login User is not authorized to submit on behalf of the given facility id:
V-RPT001-F	Validation error encountered on general report information. The specific error message is provided under the element <error>
V-RPT010-F	Invalid, missing, or duplicate Internal Control Number
V-RPT020-F	Invalid report type only
R-RPT020-F	Report type is currently not supported
V-RPT030-F	Report id is invalid
V-COR001-F	Validation error encountered on core questions. The specific error message is provided under the element <error>.
V-COR010-F	Invalid value for the element <submissiontype>.
V-COR020-F	Invalid or missing child element for the element <eventdiscovery>. At least one child element is required.
V-COR030-F	Invalid or missing value for the element <patientgender>.
R-COR030-F	The attribute -na- for the element <patientgender> is only valid for reports with a submission type of Infrastructure Failure.
R-COR040-F	The attribute -na- for the element <patientage> is only valid for reports with a submission type of Infrastructure Failure.
V-COR040-F	Invalid or missing value for the element <patientage>.
V-COR050-F	Invalid or missing value for the element <careareaname>.
V-COR060-F	Invalid or missing value for the element <admissiondate>.
R-COR060-F	The value of the element <admissiondate> must be <= the element value <eventdate>.
R-COR061-F	The attribute -na- for the element <admissiondate> is only valid for reports with a submission type of Infrastructure Failure.
R-COR070-F	The value for the element <eventdate> must be <= the batch creation date.
V-COR070-F	Invalid or missing value for the elements <eventdate> or <eventtime>.
V-COR080-F	Invalid value for the element <confirmdate>.
R-COR080-F	The element <confirmdate> is not valid if submission type is Incident.

Code	Description
R-COR081-F	The value for the element <confirmdate> must be >= the value for the elements <eventdate>.
R-COR082-F	The value for the element <confirmdate> must be <= the batch creation date.
R-COR090-F	The element <confirmcomment> is not valid if submission type is Incident.
V-COR090-F	Invalid length for the element <confirmcomment>.
V-COR100-F	Invalid, Incomplete, or missing value for event type.
R-COR100-F	The element <level2otherdesc> is required if -other- is selected on level2desccode.
R-COR101-F	The element <level3otherdesc> is required if -other- is selected on level3desccode.
V-COR110-F	Invalid or missing value for the element <eventdesc>.
V-COR120-F	Invalid or missing value for the element <harmscore>.
R-COR120-F	Reports with a submission type of Incident should have a harmscore < E.
R-COR121-F	Reports with a submission type of Serious Event should have a harmscore >= E.
V-COR130-F	Invalid or missing value for the element <likelyrecurr>.
V-COR140-F	Invalid or missing value for the element <severityrecurr>.
V-COR150-F	Invalid value for the element <recommend>.
R-COR150-F	The element <recommend> is required for reports with a submission type of serious event or infrastructure failure.
R-COR160-F	The element <eventdisp> and at least one child element is required for reports with a submission type of serious event or infrastructure failure.
V-COR160-F	Invalid value for at least one child element of the element <eventdisp>.
V-COR170-F	Invalid value for at least one child element of the element <contributingfactors> <teamfactors>.
R-COR170-F	The element <contributingfactors> <teamfactors> and at least on child element is required for reports with a submission type of serious event or infrastructure failure and a Harm Score > D.
R-COR171-F	The attribute noresponse for the element <contributingfactors> <teamfactors> is valid only when harm score < G.
R-COR171-W	If this attribute noresponse for the element <contributingfactors> <teamfactors> has a value of 1, all subsequent child elements are ignored.
R-COR172-W	If this child element <none> for the element <contributingfactors> <teamfactors> has a value of 1, all other sibling elements are ignored.
R-COR180-F	The element <contributingfactors> <workenvironment> and at least on child element is required for reports with a submission type of serious event or infrastructure failure and a Harm Score > D.
V-COR180-F	Invalid value for at least one child element of the element <contributingfactors> <workenvironment>.
R-COR181-F	The attribute noresponse for element <contributingfactors> <workenvironment> is valid only when harm score < G.
R-COR181-W	If this attribute noresponse for the element <contributingfactors> <workenvironment> has a value of 1, all subsequent child elements are ignored.
R-COR182-W	If this child element <none> for the element <contributingfactors> <workenvironment> has a value of 1, all other sibling elements are ignored.
R-COR190-F	The element <contributingfactors> <taskfactors> and at least on child element is required for reports with a submission type of serious event or infrastructure failure and a Harm Score > D.
V-COR190-F	Invalid value for at least one child element of the element <contributingfactors> <taskfactors>.

Code	Description
R-COR191-F	The attribute noresponse for element <contributingfactors> <taskfactors> is valid only when harm score < G.
R-COR191-W	If this attribute noresponse for the element <contributingfactors> <taskfactors> has a value of 1, all subsequent child elements are ignored.
R-COR192-W	If this child element <none> for the element <contributingfactors> <taskfactors> has a value of 1, all other sibling elements are ignored.
R-COR200-F	The element <contributingfactors> <staffactors> and at least on child element is required for reports with a submission type of serious event or infrastructure failure and a Harm Score > D.
V-COR200-F	Invalid value for at least one child element of the element <contributingfactors> <staffactors>.
R-COR201-F	The attribute noresponse for element <contributingfactors> <staffactors> is valid only when harm score < G.
R-COR201-W	If this attribute noresponse for the element <contributingfactors> <staffactors> has a value of 1, all subsequent child elements are ignored.
R-COR202-W	If this child element <none> for the element <contributingfactors> <staffactors> has a value of 1, all other sibling elements are ignored.
R-COR210-F	The element <contributingfactors> <patientcharacteristics> and at least on child element is required for reports with a submission type of serious event or infrastructure failure and a Harm Score > D.
V-COR210-F	Invalid value for at least one child element of the element <contributingfactors> <patientcharacteristics>.
R-COR211-F	The attribute noresponse for element <contributingfactors> <patientcharacteristics> is valid only when harm score < G.
R-COR211-W	If this attribute noresponse for the element <contributingfactors> <patientcharacteristics> has a value of 1, all subsequent child elements are ignored.
R-COR212-W	If this child element <none> for the element <contributingfactors> <patientcharacteristics> has a value of 1, all other sibling elements are ignored.
R-COR220-F	The element <contributingfactors> <organizational> and at least on child element is required for reports with a submission type of serious event or infrastructure failure and a Harm Score > D.
V-COR220-F	Invalid value for at least one child element of the element <contributingfactors> <organizational>.
R-COR221-F	The attribute noresponse for element <contributingfactors> <organizational> is valid only when harm score < G.
R-COR221-W	If this attribute noresponse for the element <contributingfactors> <organizational> has a value of 1, all subsequent child elements are ignored.
R-COR222-W	If this child element <none> for the element <contributingfactors> <organizational> has a value of 1, all other sibling elements are ignored.
V-COR230-F	Invalid length for the element <contributingfactors> <additionalinfo>.
V-COR240-F	Invalid value for at least one child element of the element <remedysituation>.
R-COR240-F	The element <remedysituation> and at least on child element is required for reports with a submission type of serious event or infrastructure failure and a Harm Score > D.
R-COR241-F	The attribute noresponse for element <remedysituation> is valid only when harm score < G.
R-COR241-W	If this attribute noresponse for the element <remedysituation> has a value of 1, all subsequent child elements are ignored.
R-COR242-W	If this child element <none> for the element <remedysituation> has a value of 1, all other sibling elements are ignored.

Code	Description
R-COR250-F	The element <jcahoqualify > is required for reports with a submission type of serious event or infrastructure failure and a Harm Score > D.
V-COR250-F	Invalid value for the element <jcahoqualify>.
R-COR251-F	The attribute noresponse for element <jcahoqualify > is valid only when harm score < G.
R-COR260-F	The element <rootcause> and at least on child element is required for reports with a submission type of serious event or infrastructure failure and a Harm Score > D.
V-COR260-F	Invalid value for at least one child element of the element <rootcause>.
R-COR261-F	The attribute noresponse for element <rootcause> is valid only when harm score < G.
R-COR261-W	If this attribute noresponse for the element <rootcause> > has a value of 1, all subsequent child elements are ignored.
R-COR262-W	If this child element <norootanalysis> for the element <rootcause> has a value of 1, all other sibling elements are ignored.
R-COR263-F	The element <rootcause1other> is required if the code provided for the element <rootcausecode1> is for -Other-.
R-COR264-F	The element <rootcause2other> is required if the code provided for the element <rootcausecode2> is for -Other-.
R-COR265-F	The element <rootcause3other> is required if the code provided for the element <rootcausecode3> is for -Other-.
V-COR266-F	The element <rootcause1>, <rootcause2> and <rootcause3> must be different values
V-COR270-F	Invalid value for at least one child element of the element <causalcode>.
R-COR270-F	The element <causalcode> and at least on child element is required for reports with a submission type of serious event or infrastructure failure and a Harm Score > D.
R-COR271-F	The attribute noresponse for element <causalcode> is valid only when harm score < G.
R-COR271-W	If this attribute noresponse for the element <causalcode> has a value of 1, all subsequent child elements are ignored.
R-COR272-W	If this child element <none> for the element <causalcode> has a value of 1, all other sibling elements are ignored.
R-COR280-F	The element <additionalcost> and at least on child element is required for reports with a submission type of serious event or infrastructure failure and a Harm Score > D.
V-COR280-F	Invalid value for at least one child element of the element <additionalcost>.
R-COR281-F	The attribute noresponse for element <additionalcost> is valid only when harm score < G.
R-COR281-W	If this attribute noresponse for the element <additionalcost> has a value of 1, all subsequent child elements are ignored.
R-COR282-W	If this child element <none> for the element <additionalcost> has a value of 1, all other sibling elements are ignored.
V-COR290-F	Invalid length for the element <othercomments>.
V-COR300-F	Invalid or missing value for the element <patientstatus>.
V-COR310-F	Invalid or missing value for the element <healthit>.
V-EVD001-F	Validation error encountered on event detail. The specific error message is provided under the element <error>.
V-EVD010-F	Invalid or missing value specified for the attribute - type.
V-MED001-F	Validation error encountered on medication error questions. The specific error

Code	Description
	message is provided under the element <error>.
V-MED010-F	Invalid value for at least one child element of the element <medicationstage>.
V-MED020-F	Invalid value for at least one child element of the element <medprescribed>.
V-MED021-F	The element <medprescribed><otherpresroute> is required if the value of the element <medpresroute> is: 14 – Other.
V-MED030-F	Invalid value for at least one child element of the element <medadministered>.
R-MED030-F	If the attribute ans for the element <medadministered> has the value of 1 then child elements are required.
R-MED031-W	If the attribute -ans- for the element <medadministered> has a value of 1 – Yes, or 3 – Not Applicable, the subsequent child elements should NOT be provided. If sibling elements are provided, they are ignored. If the attribute -ans- for the element <medadministered> has a value of 2 – No, the subsequent child elements MUST be provided.
V-MED032-F	The element <medadministered><otheradminroute> is required if the value of the element <medadminroute> is: 14 – Other.
V-MED040-F	Invalid value for the element <numdoses>.
V-MED050-F	Invalid value for the element <doseappro>.
V-MED060-F	Invalid value for at least one child element of the element <ordertype>.
V-MED070-F	Invalid value for the element <patientweight >.
V-MED080-F	Invalid value for at least one child element of the element <medsource>.
V-MED090-F	Invalid length for the element <causedmederr>.
R-MED100-F	The element <contributingfactors> is required for reports with a harm score > D.
R-MED101-F	The attribute noresponse for element <contributingfactors> is valid only when harm score < G.
R-MED101-W	If this attribute noresponse for the element <contributingfactors> has a value of 1, all subsequent child elements are ignored.
V-MED110-F	Invalid value for at least one child element of the element <contributingfactors><prescribing>.
R-MED111-W	If the child element <none> for the element <contributingfactors><prescribing> has a value of 1, all subsequent sibling elements are ignored.
V-MED120-F	Invalid value for at least one child element of the element <contributingfactors><transcription>.
R-MED121-W	If the child element <none> for the element <contributingfactors><transcription> has a value of 1, all subsequent sibling elements are ignored.
V-MED130-F	Invalid value for at least one child element of the element <contributingfactors><preparation>.
R-MED131-W	If the child element <none> for the element <contributingfactors><preparation> has a value of 1, all subsequent sibling elements are ignored.
V-MED140-F	Invalid value for at least one child element of the element <contributingfactors><administration>.
R-MED141-W	If the child element <none> for the element <contributingfactors><administration> has a value of 1, all subsequent sibling elements are ignored.
V-MED150-F	Invalid value for at least one child element of the element <contributingfactors><monitoring>.
R-MED151-W	If the child element <none> for the element <contributingfactors><monitoring> has a value of 1, all subsequent sibling elements are ignored.
V-MED160-F	Invalid value for at least one child element of the element <contributingfactors><patientfactors>.
R-MED161-W	If the child element <none> for the element <contributingfactors><patientfactors> has a value of 1, all subsequent sibling elements are ignored.

Code	Description
R-MED170-F	The element <hialertmed> is required for reports with a harm score > D.
V-MED170-F	Invalid value for the element <hialertmed>.
R-MED171-F	The child element <hialertmedname> is required if the value for the element <hialertmed> = yes.
V-ADR001-F	Validation error encountered on adverse drug reaction questions. The specific error message is provided under the element <error>.
V-ADR010-F	Invalid or missing value for at least one child element of the element <suspectedmed>.
V-ADR020-F	Invalid value for at least one child element of the element <addlsuspectedmed>.
V-ADR030-F	Invalid value for the element <adrabated>.
V-ADR040-F	Invalid value for the element <adrreappeared>.
V-ADR050-F	Invalid value for the element <drugappropriate>.
V-ADR060-F	Invalid value for the element <testperformed>.
V-ADR070-F	Invalid value for the element <toxicdocumented>.
V-ADR080-F	Invalid value for the element <toxicdocumented>.
V-ADR090-F	Invalid value for at least one child element of the element <adrinteraction>.
V-ADR100-F	Invalid value for the element <noncompliance>.
V-ADR110-F	Invalid value for the element <causalrelation>.
R-ADR110-F	The element <causalrelation> is required for reports with a harm score > D.
R-ADR111-F	The attribute noresponse for element <causalrelation> is valid only when harm score < G.
R-ADR111-W	If the attribute noresponse for the element <causalrelation> has a value of 1, the value for element <causalrelation> is ignored.
R-ADR120-F	The element <severityindex> is required for reports with a harm score > D.
V-ADR120-F	Invalid value for the element <severityindex>.
R-ADR121-F	The attribute noresponse for element <severityindex> is valid only when harm score < G.
R-ADR121-W	If the attribute noresponse for the element <severityindex> has a value of 1 the value for element <severityindex> is ignored.
V-EQP001-F	Validation error encountered on equipment, supplies, and devices questions. The specific error message is provided under the element <error>.
V-EQP010-F	Invalid length for the element <equipmentname>.
V-EQP020-F	Invalid length for the element <manufacturer>.
V-EQP030-F	Invalid length for the element <modelno>.
V-EQP040-F	Invalid length for the element <serialno>.
V-EQP050-F	Invalid length for the element <lotno>.
V-EQP060-F	Invalid value for the element <removedservice>.
V-EQP070-F	Invalid length for the element <engineeringno>.
V-EQP080-F	Invalid length for the element <biomedicalno>.
V-FAL001-F	Validation error encountered on fall questions. The specific error message is provided under the element <error>.
V-FAL010-F	Invalid value for the element <witnessed>.
V-FAL020-F	Invalid value for the element <lostconscious>.
V-FAL030-F	Invalid value for the element <alteredmental>.
V-FAL040-F	Invalid value for the element <unabletorise>.
V-FAL050-F	Invalid value for the element <elimination>.
V-FAL060-F	Invalid value for the element <dizziness>.

Code	Description
V-FAL070-F	Invalid value for the element <depressed>.
V-FAL080-F	Invalid value for the element <protocolinplace>.
R-FAL081-F	The element <protocoltype> is required if the value of the element <protocolinplace> is -Yes-.
V-FAL090-F	Invalid value for the element <restraintsinplace>.
R-FAL091-F	The element <protocoltype> is required if the value of the element <restraintsinplace> is -Yes-.
V-FAL100-F	Invalid value for the element <sitterinplace>.
V-FAL110-F	Invalid value for the element <druginduced>.
V-FAL120-F	Invalid value for at least one child element of the element <medreceived>.
V-FAL130-F	Invalid value for the element <assmtcomplete>.
V-FAL140-F	Invalid value for the element <atrisk>.
V-FAL150-F	Invalid value for the element <levelofinjury>.
V-PTT001-F	Validation error encountered on error related to procedure, treatment, and test questions. The specific error message is provided under the element <error>.
V-PTT010-F	Invalid value for the element <identifyptt>.
V-SKN001-F	Validation error encountered on skin integrity questions. The specific error message is provided under the element <error>.
V-SKN010-F	Invalid value for the element <idatrisk>.
V-SKN020-F	Invalid value for the element <stage>.
R-HIT010-F	The elements <hithealthsystem> <hitadmin> or <hithealthsystem> <hitadmin> or <hithealthsystem> <hitadmin> and at least on child element are required for reports with a value of YES for <healthit>.
R-HIT020-F	The element <hitcontributingfactors> <hitequip> or <hitcontributingfactors> <hitergo> or <hitcontributingfactors> <hitcfo> and at least on child element are required for reports with a value of YES for <healthit>.
R-HIT030-F	The element <hitman> <hitmanapp> and <hitman> <hitmannme> must be provided for reports with a value of YES for <healthit> if <hitman><hitmanunk> is not 1.
V-HIT010-F	Invalid value for at least one child element of the element <hithealthsystem> <hitadmin>.
V-HIT020-F	Invalid value for at least one child element of the element <hithealthsystem> <hitehr>.
V-HIT030-F	Invalid value for at least one child element of the element <hithealthsystem> <hitmisc>.
V-HIT040-F	Invalid value for at least one child element of the element <hitcontributingfactors> <hitequip>.
V-HIT050-F	Invalid value for at least one child element of the element <hitcontributingfactors> <hitergo>.
V-HIT060-F	Invalid value for at least one child element of the element <hitcontributingfactors> <hitcfo>.
R-HIT090-W	If the response for the element <hitman> <hitmanunk> has a value of 1, all subsequent child elements are ignored.
V-INT001-F	Internal Processing Error.