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1. Statement of Purpose

1.1. To establish a system and processes for the management of sentinel events identification, reporting, investigation and corrective action plan and ensure adherence to these processes for the purpose of improving healthcare and patient safety with maintain just culture.

1.2. Ensure effective analysis (RCA) for all sentinel events and improvement of the processes to prevent reoccurrence.

2. Applicability

2.1. This policy applied to all healthcare facilities and staff regulated by Ministry of Health (MOH).

3. Definitions/Abbreviations

3.1. **Sentinel Event:** A patient safety issue that is not primarily related to the natural course of the patient's illness or underlying condition of a patient that reached the patient and resulted in death, permanent or severe temporary harm.

3.2. **Event Occurrence Date:** the date of the event happened

3.3. **Internal Notification Date:** The date when the event notified inside the facility

3.4. **Severe Temporary Harm:** refers to a critical, potentially life-threatening harm lasting for a limited time (less than 4 months) with no permanent residual but requires transfer to a higher level of care/monitoring for a prolonged period of time (four to six months), transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition.

3.5. **Healthcare facilities:** The facility that provide health care which include hospital, PHCs, dental care centers, and specialized care centers.

3.6. **Healthcare facilities premises:** refer to all property utilized by the facility, offices, housing, parking lots, warehouse and any other areas under the jurisdiction of the healthcare facility.

3.7. **Invasive procedure:** An invasive procedure is one where purposeful/deliberate access to the body is gained via an incision, percutaneous puncture, where instrumentation is used in addition to the puncture needle, or instrumentation via a natural orifice. It begins when entry to the body is gained and healthcare professionals perform ends when the instrument is removed, and/or the skin is closed.

3.8. **Measures of Effectiveness:** It is a measurement data to quantify the recommended action plan and the staff comply with recommended changes and if the changes made a difference.

3.9. **Newborn:** a newborn is from birth to 28 days

3.10. **Infant:** A young baby, from 29 days to 12 months of age.

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3.11. **Child:** Any person from 1 year till 14 years.

3.12. **Root cause analysis (RCA):** is a structured retrospective analysis of an event or situation that aims to identify its true causes and the actions needed to eliminate them, using a wide range of approaches, tools and techniques to uncover causes

3.13. **Action Plan:** The product of the root cause analysis is an action plan that identifies the strategies that the organization intends to implement in order to reduce the risk of similar events occurring in the future.

3.14. **RCA team:** A multidisciplinary team consists of representation from departments such as but not limited to the following: quality, risk management, medical, nursing, & others as deemed necessary.

3.15. **Most Responsible Physician (MRP)** refers to the physician who has overall responsibility for the care and management of an individual patient during the patient's hospital stay.

3.16. **Safety Event Report (SER) /Occurrence Variance Report (OVR)** refers to any undesired incidents that may affect patients, employees, family members, visitors, facility, equipment, or property, which is not consistent with standard operations of care. These incidents may cause actual injury/damage or have the potential to cause injury, loss of function, or death.

3.17. **MOH:** Ministry of Health

3.18. **RHD:** Regional Health Directorate

3.19. **SE:** Sentinel Event

3.20. **RCA:** Root Cause Analysis

3.21. **CAP:** Corrective Action Plan

3.22. **OVR**: Occurrence Variance Report

4. Policy

4.1. Sentinel events shall be reported and managed with just culture for the purpose of continuous learning and improvement.

4.2. All Health care facilities should develop Sentinel events policy aligned with this sentinel events policy.

4.3. All Sentinel Events shall be reported within 48 hours after discovery to the MOH sentinel event portal as per facility approved policy (Appendix 1) and Minister Memorandum (Appendix 2) .

4.4. The defined sentinel events categories (Appendix -3) are the minimum categories. Health care facility can define more categories as needed per their approved policy.

4.5. The Sentinel events could be identified during providing service or during review the following but not limited to:

4.5.1. Safety Reporting System / Occurrence Variance Report (OVR)

4.5.2. Patient safety complains

4.5.3. Mortality and morbidity reviews

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4.5.4. Departmental morning meeting

4.5.5. Social media

4.5.6. Direct request by high authority.

4.6. If the General Directorate of Quality and Patient safety (GD-QPS) capture sentinel event from any sources, the GD-QPS will send an email to related facility to report the event on the MOH portal. The related facility should response to the email within 24h working hours from submitted email. If the facility did not respond to the first email, the GD-QPS will activate the escalation mechanism (Appendix 4).

4.7. The health care facility general director should be notified within 24 hours from discovery of the event.

4.8. The health care facility general director or his/her designee activate RCA review committee

4.8.1. The RCA review committee consists of four to six people from a mix of different professionals as per the nature of sentinel event's needs.

4.8.2. The RCA review committee should not include individual involved in the event

4.8.3. The RCA review committee has the right to interviews individuals at all level of the organization who were involved in the sentinel event or have knowledge of the issues and processes involved in the event

4.8.4. At least one member of the team has an experience in the RCA work flow process and is knowledgeable in conducting RCA.

4.9. The RCA team has the right to seek subject matter expert opinion outside facility with support of the facility general director.

4.9.1. If the sentinel event outcome was patient death:

4.9.1.1 The medical record file of the patient who had the sentinel event shall be secured with controlled access to avoid modification in documentation or documenting post event.

4.9.1.2 The RCA review committee shall be granted access to patient medical record file all documentation related to patient care.

4.9.2 If the sentinel event outcome was not patient death such as lose of organ or limb:

4.9.2.1 The patient medical record file for the episode where the sentinel event occurred copy and secured with controlled access and the original released for continuity of the patient care to avoid modification in documentation or documenting post event.

4.9.2.2 The RCA review committee shall be granted access to the copy of the patient file and all documentation related to patient care.

4.9.2.3 The health care facility shall ensure controlled and secured access to the devices involved in sentinel event and retrieve data record for the episode of patient care.

4.10 The RCA committee start to gather the information from all possible sources and not limited to:

4.10.1 Patient file (paper and electronic)

4.10.2 Other documentations such as, inspection report, letters or patient statement

4.10.3 Forms related to the event

4.10.4 Site observation

4.10.5 Interview, physical evidence or pictures

4.11 Gathered information will be organized in a chronological order using one of the following tools:

4.11.1 Narrative chronology

4.11.2 Time Person Grid

4.11.3 Flow chart

4.11.4 Information matrix.

4.12 The QPS in the RHD/Cluster shall ensure the quality and appropriateness of Sentinel events Root Cause Analysis (RCA) and the corrective action plan before the final submission to MOH.

4.13 The approved Sentinel events Root Cause Analysis (RCA) and the corrective action plan shall be submitted within thirty (30) working days from discovery of event to MOH sentinel Portal (Appendix 1).

4.14 The RCA focuses primarily on systems and processes review. The review must identify potential improvements that would eliminate or decrease the likelihood of the sentinel events reoccurrence in the future.

4.15 Quality and Patient Safety Department in the facility in coordination with the related department shall developed the measures to monitor the effectiveness of corrective action plan.

4.16 Quality and Patient Safety Department in the facility monitors the submitted actions status and the measures of effectiveness for the corrective action plan, which was created by responsible department.

4.17 The health care facility general director ensures implementation of the corrective action plan and communicate the support as needed (Appendix 1).

4.18 The MOH specialty lead review the RCAs as a subject matter expert for appropriateness review for the recommendation and corrective action plan.

4.19 In the clustered regions, if the sentinel event involves two or more MOH facilities within the same cluster:

4.19.1 The sentinel events involve two or more MOH facilities within the cluster, the quality and patient safety in the cluster shall facilitate the RCA review and the team formation.

4.19.2 The sentinel events involve two or more MOH facilities and private sector within the same region the quality and patient safety in the RHD shall facilitate the RCA review and the team formation.

4.20 In the un-clustered regions, if the sentinel event involves two or more facilities within the same region:

4.20.1 The sentinel events involve two or more facilities MOH or Private sectors within the same region, the quality and patient safety in the RHD shall facilitate the RCA review and the team formation in coordination with relevant sector directorate.

4.20.2 The sentinel event involves two or more facilities in two different regions (Cluster, RHD, Other Governmental sectors and Private sectors), the GD-QPS shall facilitate the RCA and team formation in coordination with relevant deputyship in MOH.

4.21 The healthcare facility reporting a sentinel event must take all precautions to ensure confidentiality and security of the reported event.

4.22 The Quality and Patient Safety departments in the facility disseminate lessons learned and produce Alert.

4.23 The Quality and Patient Safety at the RHD/Clusters disseminate lessons learned between the facilities within the region/Cluster and produce Alert.

4.24 The General Directorate of Quality and Patient Safety in MOH disseminate lessons learned among all the regions/Clusters and produce Alert on regular bases. Report of lessons will disseminate to the General Directorate of Hospitals Affaires on Quarter Bases.

4.25 The disclosure of sentinel events to the patients or their families shall be conducted by understandable language as per the MOH disclosure policy.

4.25.1 The initial disclosure shall be conducted immediately upon discovering the incident by the attending team.

4.25.2 The final disclosure shall be provided to the patient upon the completeness the RCA by treating team with coordination with hospital leadership.

4.26 The health care facility should provide the needed support to the staff involved in the sentinel event such as but not limited to a legal or psychological support as per the second victim program.

4.27 The quality and patient safety in RHD/Cluster ensure providing training as needed to the staff in the health care facilities.

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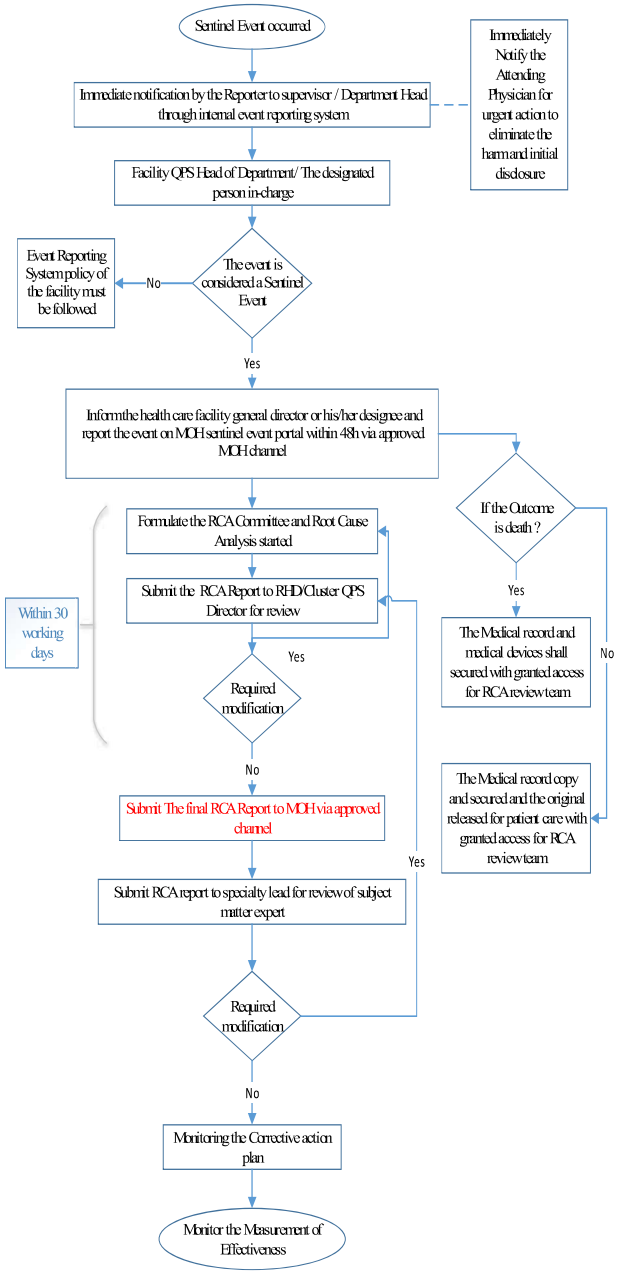
5 Procedure Flowchart



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6 Performance Measurement

6.1 Measuring of Complying with 48 hours reporting time to MOH Portal.

6.2 Measuring of Complying with 30 working days of submitting time to approved MOH channel

6.3 Percentage of sentinel event reported outside the portal

6.4 Percentage of strong action post patient safety event from social media

6.5 Patient perception about patient safety

6.6 Percentage of closing recommendation from RCA

6.7 Quality of RCA

7 Related References

7.1 JCI 7th edition hospital standards January 2021.

7.2 CBAHI 3rd edition Standards 2016.

7.3 Guideline for Neonatal Care, Saudi Ministry of Health

7.4 Child protection law, Bureau of Expert at the Council of Ministries, 26/12/2014

7.5 Munetz MR, Lidz CW, Meisel A. Informed consent and incompetent medical patients. J Fam Pract. 1985 Mar;20(3):273-9. PMID: 3156207.

7.6 International Labour Office ILO International Council of Nurses ICN, World Health Organization WHO

7.7 Public Services International PSI, Joint program on Workplace Violence in the Health Sector, Geneva, 2002

8 Attachments:

8.1 Appendix – 1 Electronic Report Form and Root Cusses Analysis Electronic Form

8.2 Appendix – 2 Minister Memorandum

8.3 Appendix – 3 MOH sentinel events categories

8.4 Appendix – 4 Escalation Mechanism

9 Responsibilities

9.1 General Directorate of Quality and Patient safety ensure monitor and support the implementation of the sentinel event policy by healthcare facilities regulated by Ministry of Health (MOH).

9.2 General Director in the RHD/Chief Executive Officer (CEO) in Cluster ensure monitor and support the implementation of the sentinel event policy by healthcare facilities within RHD/Cluster.

9.3 general director of health care facility ensure monitor and support the implementation of the sentinel event policy by healthcare facility.

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Approvals			
Approved By:	**Dr. Faisal Dahmashi** Assistant Deputy Minister for Hospital Services		21.2.2022
		Signature	Date
Approved By:	**Eng. Khalid Saud Altala** Assistant Deputy Minister for Planning and Organization Excellence		23.2.2022
		Signature	**Effective Date**

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Appendix 1 – Electronic Report Form and Root Cusses Analysis Electronic Form

Please select the most relevant event:

◯ Abduction of any patient (Newborn/Infant/Child/Adult) receiving care within a healthcare facility ◯ Discharge or handing of a newborn or an infant to the wrong family ◯ Discharge of a Minor or Incapacitated Patient to an unauthorized person ◯ Suicide, attempted suicide, or self-harm of any patient in a healthcare setting or within 72 hours of discharge ◯ Staff Suicide, attempted suicide, or self-harm that results in severe temporary harm, permanent harm, or death. ◯ Invasive diagnostic or therapeutic procedure or surgery, on the wrong patient, wrong site or side, wrong implant ◯ Fertilizing wrong sperm to wrong ovum, or implant wrong embryo to wrong mother, or unexpected damage to embryos, sperm, eggs, or frozen tissue, which is, underwent fertilization in infertility centers ◯ Administration of incompatible ABO, Non-ABO of blood/ blood products, or transplantation of incompatible organs ◯ Unintended retention of a foreign object in a patient after invasive procedure, including surgery ◯ Unexpected Death of a full-term Newborn ◯ Rape cases encountered within the premises/campus of a healthcare facility.	◯ Medication error leading to severe temporary harm, permanent harm, or death. ◯ Patient severe temporary harm, permanent harm, or death associated with intravascular air embolism ◯ Patient severe temporary harm, permanent harm, or death because of medical device breakdown or failure when in use ◯ Unexpected building collapse, or malfunctioning structure or overturning of any healthcare facility load bearing part of any lift or lifting equipment when in use or during installation ◯ Transfusing/ transplantation of contaminated blood, blood products, organ or tissue or transmission of disease as a result of using contaminated instruments or equipment provided by the healthcare facility ◯ Death or serious disability associated with failure to manage/identify neonatal hyperbilirubinemia ◯ Delivery of radiotherapy to the wrong body region or dose exceeds more than 25% of the total planned radiotherapy dose ◯ Patient severe temporary harm, permanent harm, or death because of patient fall ◯ Patient severe temporary harm, permanent harm, or death associated with administration/ connection of the wrong medical gas ◯ System failure leading to service interruption and total evacuation outside healthcare facility

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◯ Assault or homicide of any patient receiving care, treatment, and services at the health care facility setting ◯ Assault or homicide of Visitor or Watcher receiving care, treatment, and services at the healthcare facility setting ◯ Physical and Psychological violence, or homicide of a staff member, or vendor at the healthcare facility setting ◯ Fire, flame, unanticipated smoke, or flashes occurring within a healthcare facility ◯ Unauthorized departure of the patient (absconded) while on care from the healthcare facility that resulted in severe temporary harm, permanent harm, or death.	◯ Unexpected death ◯ Unexpected Loss of a limb or a function ◯ Maternal death, permanent harm, severe temporary harm ◯ MR damage or Patient or staff severe temporary harm, permanent harm, or death associated with introduction of a metallic object ◯ Loss or damage to specimen sample or tissue biopsy after invasive procedure ◯ Others:
After Analysis, was this event considered to be: ◯ Preventable ◯ non-Preventable	Disclosure to Patient/Family: ◯ Yes ◯ No By whom:

Person Affected Outcome:	◯ Death ◯ Permeant Harm: loss of an organ/function, etc. ◯ Sever Temporary Harm: Transfer to Critical Care, long stay, addition surgery, etc. ◯ No Harm

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Healthcare Facility Information:

RCA Number		Event Occurrence Location	
Event Date		Event Time	
Hospital		Region	
Immediate Actions Taken			
Brief Description			
Event Identification Date		Event Source of Notification	
		Classification of Person Affected: • Employee • Visitor • Watcher • Inpatient • Outpatient • Emergency • Not applicable	
Pre-Event Diagnosis			
Involved Departments:		RHD/Cluster	

Event information:

MRN#		Gender	
First Name		Admission Date	
Middle & Last Name		MRP Badge Number	
DOB		MRP Name	
Age		MRP Department:	
Nationality		Resident Involved?	
Current Diagnosis			
Documented Allergy			
Gestational Age			
Weight (Kg)			
Height (cm)			

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Fill below table for the maternity and infant related events:

This to be filled when unanticipated death of a full-term infant		This to be filled when an infant discharged to the wrong family.	
Booked mother?	• Yes, • No	1st baby Mother's MRN	
Antenatal care	• Yes, • No	1st baby Mother's Name	
Mother's MRN		2st baby MRN	
Mother's Name		2st baby Mother's MRN	
Mother's DOB		2st baby Mother's Name	
Mother's Age			

RCA Team Members

Name	Position /Title	RCA Role	Received RCA training?
			• Yes • No
			• Yes • No
			• Yes • No
			• Yes • No
			• Yes • No
			• Yes • No

List Staff Involved

Name	Badge No.	Interviewed?	Job Title	Privilege Status	Credentials Status
		• Yes • No			
		• Yes • No			
		• Yes • No			
		• Yes • No			
		• Yes • No			
		• Yes • No			

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Invited Guests

Name	Position /Title	RCA Role	Received RCA training?

Staffing Information

Number of float (nurses pulled out from other units) in staff	
Nurse /Patient Ratio in the time of event	
Total Number of staff	
Total Number of Patients in the time of event	
Total new admissions and Patient transferred	
Total Number of OR Patients	
Number of patients with high acuity	

Sequence of Events (from nursing note)

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Date and Time (DD/MM/YY HH:MM AM/PM)	Events From Chart Review

List of Related Policy and Procedure/s:

Attachment No.	Attachment File Name

Narrative of the event (including OR, Imaging, Labs and other reports in chronological order) :

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Appendix 2 - Cause and Effect Analysis Investigation Form

A. Equipment / Supplies Factors

A1. Was there any equipment factor in this event?
(Note: If unsure review the causes listed below)

◯ No
◯ Yes. If yes, why? Would correction eliminate reoccurrence? (if "Yes" tick "Root cause", if "No" tick "contributing factor":

Check all that apply ↓ Then →	**Describe the deviation and the cause**	**Check Appropriate Column**	
		Root Cause	Contributing Factor

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Displays ◯ Incorrect information / feedback available ◯ Inconsistent or unclear information ◯ Illegible information ◯ Interference/unclear equipment display **Integrity** ◯ Poor working order ◯ Inappropriate size ◯ Unreliable ◯ Ineffective safety features / not designed to fail safe ◯ Poor maintenance program ◯ Failure of general services (power supply, water, piped gases etc.) **Positioning** ◯ Correct equipment not available ◯ Insufficient equipment/emergency backup equipment ◯ Incorrectly placed for use ◯ Incorrectly stored **Usability** ◯ Unclear controls ◯ Not intuitive in design ◯ Confusing use of colour or symbols ◯ Lack of or poor-quality user manual ◯ Not designed to make detection of problems obvious ◯ Use of items which have similar names or packaging			

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◯ Problems of compatibility ◯ Other:			

A. Equipment / Supplies Factors (continued)

A2. Was there a distribution of supplies (including meds, IVs, Blood) factor in this event?
(Note: If unsure review the causes listed below)
◯ No
◯ Yes. Ifyes, why? Would correction eliminate reoccurrence? (if "Yes" tick "Root cause", if "No" tick "contributing factor":

Check all that apply ↓ Then →	**Describe the deviation and the cause**	**Check Appropriate Column**	
		Root Cause	Contributing factor
◯ Similar appearance to like product ◯ Inconsistent location for supply ◯ Unclear labeling of supply ◯ Inconsistent methods & procedures ◯ Procedure not identified / followed ◯ Other:			

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B. Work Environment Factors

B1. Was the design of the facility a factor in this event?
(Note: If unsure review the causes listed below)

◯ No
◯ Yes. Ifyes, why? Would correction eliminate reoccurrence? (if "Yes" tick "Root cause", if "No" tick "contributing factor":

Check all that apply → Then	Describe the deviation and the cause	Check Appropriate Column	
		Root Cause	Contributing factor
◯ Poor or inappropriate office design (computer chairs, height of tables, anti-glare screens, security screens, panic buttons, placing of filing cabinets, storage facilities, etc.) ◯ Poor or inappropriate area design (length, shape, visibility, provision of space) ◯ Inadequate security provision ◯ Lack of secure outside space ◯ Inadequate lines of sight ◯ Inadequate/inappropriate use of color contrast/patterns (walls/doors/flooring etc.) ◯ Other:			

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B2. Was the environment of the facility a factor in this event?
(Note: If unsure review the causes listed below)

◯ No
◯ Yes. Ifyes, why? Would correction eliminate reoccurrence? (if "Yes" tick "Root cause", if "No" tick "contributing factor":

Check all that apply ↓ Then →	**Describe the deviation and the cause**	**Check Appropriate Column**	
		Root Cause	Contributing factor
◯ Facility not available (failure or lack of capacity) ◯ Fixture or fitting not available (failure or lack of capacity) ◯ Ligature/anchor points ◯ Housekeeping issues – lack of cleanliness ◯ Temperature too high/low ◯ Lighting too dim or bright, or lack of ◯ Noise levels too high or low ◯ Distractions ◯ Other:			

B. Work Environment Factors (continued)

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B3. Is there was an **administrative environment factor in this event?**
(Note: If unsure review the causes listed below)

◯ No
◯ Yes. Ifyes, why? Would correction eliminate reoccurrence? (if "Yes" tick "Root cause", if "No" tick "contributing factor":

Check all that apply → Then	**Describe the deviation and the cause**	**Check Appropriate Column**	
		Root Cause	Contributing factor
◯ Unreliable or ineffective general administrative systems (Please specify e.g.: Bookings, Patient identification, ordering, requests, referrals, appointments) ◯ Unreliable or ineffective administrative infrastructure (e.g. Phones, bleep systems etc.) ◯ Unreliable or ineffective administrative support ◯ Other:			

B4. Was Staffing, Work load, and hours of work a factor in this event?
(Note: If unsure review the causes listed below)

◯ No
◯ Yes. Ifyes, why? Would correction eliminate reoccurrence? (if "Yes" tick "Root cause", if "No" tick "contributing factor":

Check all that apply → Then	**Describe the deviation and the cause**	**Check Appropriate Column**	
		Root Cause	Contributing factor
◯ Inappropriate skill mix (e.g., Lack of senior staff; Trained staff; Appropriately trained staff) ◯ Low staff to patient ratio			

◯ No / inaccurate workload / dependency assessment ◯ Use of temporary staff ◯ High staff turnover ◯ Shift related fatigue ◯ Excessive working hours ◯ Lack of breaks during work hours ◯ Excessive extraneous tasks ◯ Lack of social relaxation, rest and recuperation ◯ Delays caused by system failure or design ◯ Time pressure ◯ Other:			

C. Patient Factors

C1. Did clinical conditions, physical, or mental/psychological factors of the patient contributed to this event? (Note: If unsure review the causes listed below)

◯ No

◯ Yes. Ifyes, why? Would correction eliminate reoccurrence? (if "Yes" tick "Root cause", if "No" tick "contributing factor":

Check all that apply ↓ Then →	**Describe the deviation and the cause**	**Check Appropriate Column**	
		Root Cause	Contributing factor
◯ Pre-existing co-morbidity ◯ Complexity of condition ◯ Seriousness of condition ◯ Limited options available to treat condition ◯ Disability ◯ Poor general physical state ◯ Malnourished			

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◯ Dehydrated ◯ Age related issues ◯ Obese ◯ Poor sleep pattern ◯ Motivation issue ◯ Stress / Trauma ◯ Existing mental health disorder ◯ Lack of intent ◯ Lack of mental capacity ◯ Learning Disability ◯ Unable/Unwilling to follow directions ◯ Other: Poor compliance in responding to health care team Instruction.			

C2. Were patient's social factors and interpersonal relationships an issue in this event? (Note: If unsure review the causes listed below)

◯ No

◯ Yes. Ifyes, why? Would correction eliminate reoccurrence? ◯ No ◯ Yes

Check all that apply ↓ Then →	**Describe the deviation and the cause**	**Check Appropriate Column**	
		Root Cause	Contributing factor
◯ Cultural / religious beliefs ◯ Language ◯ Lifestyle (smoking/ drinking/ drugs/diet)			

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◯ Sub-standard living accommodation (e.g. dilapidated) ◯ Life events ◯ Lack of support networks ◯ Engaging in high-risk activity ◯ Staff to patient and patient to staff ◯ Patient engagement with services ◯ Staff to family and family to staff ◯ Patient to patient ◯ Family to patient or patient to family ◯ Family to family (siblings, parents, children) ◯ Other:			

D. Staff Factors

D1. Were physical, psychological, or social domestic issues of the staff a factor in this event? (Note: If unsure review the causes listed below)

◯ No

◯ Yes. Ifyes, why? Would correction eliminate reoccurrence? (if "Yes" tick "Root cause", if "No" tick "contributing factor":

Check all that apply → Then	Describe the deviation and the cause	Check Appropriate Column	
		Root Cause	Contributing factor
Physical ◯ Poor general health (e.g. nutrition, hydration, diet, exercise, fitness) ◯ Disability (e.g. eyesight problems, dyslexia) ◯ Fatigue ◯ Infected healthcare worker **Psychological** ◯ Stress (e.g. distraction / preoccupation) ◯ Specific mental illness (e.g. depression)			

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◯ Mental impairment (e.g. illness, drugs, alcohol, pain) ◯ Lack of motivation (e.g. boredom, complacency, low job satisfaction) **Social Domestic** ◯ Domestic problems (e.g. family related issues) ◯ Lifestyle problems (e.g. financial/housing issues) ◯ Cultural beliefs ◯ Language ◯ Other:			

D2. Did personality issues or cognitive factors contributed to this event?
(Note: If unsure review the causes listed below)
◯ No
◯ Yes. Ifyes, why? Would correction eliminate reoccurrence? (if "Yes" tick "Root cause", if "No" tick "contributing factor":

Check all that apply ↓ Then →	Describe the deviation and the cause	Check Appropriate Column	
		Root Cause	Contributing factor
Personality Issues ◯ Low self-confidence / over confidence (e.g. gregarious, reclusive, interactive) ◯ Risk averse / risk taker ◯ Bogus healthcare worker **Cognitive factors** ◯ Preoccupation / narrowed focus (situational awareness problems)			

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◯ Perception/viewpoint affected by information or mindset (expectation/confirmation bias) ◯ Inadequate decision/action caused by group influence ◯ Distraction / attention deficit ◯ Overload ◯ Boredom ◯ Other:			

E. Task Factors

E1. Were standards (policies, procedures, regulations) or compliance to standards a factor in this event?
(Note: If unsure review the causes listed below)
◯ No
◯ Yes. Ifyes, why? Would correction eliminate reoccurrence? (if "Yes" tick "Root cause", if "No" tick "contributing factor":

Check all that apply → Then	**Describe the deviation and the cause**	**Check Appropriate Column**	
		Root Cause	Contributing factor
◯ Not up-to-date ◯ Unavailable at appropriate location (e.g. Lost/ missing/non-existent/not accessible when needed) ◯ Unclear/not useable (ambiguous; complex; irrelevant, incorrect) ◯ Not adhered to / not followed ◯ Not monitored / reviewed ◯ Inappropriately targeted / focused (i.e. not aimed at right audience) ◯ Inadequate task disaster plans and drills			

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◯ Compliance to standard not enforced ◯ Barriers to comply with standards ◯ Other:			

E2. Were decision making aids a factor in this event?
(Note: If unsure review the causes listed below)
◯ No
◯ Yes. Ifyes, why? Would correction eliminate reoccurrence? (if "Yes" tick "Root cause", if "No" tick "contributing factor":

Check all that apply ↓ Then →	**Describe the deviation and the cause**	**Check Appropriate Column**	
		Root Cause	Contributing factor
◯ Aids not available (e.g. CTG machine; checklist; risk assessment tool; fax machine to enable remote assessment of results) ◯ Aids not working (e.g., CTG machine, risk assessment tool, fax machine) ◯ Difficulties in accessing senior / specialist advice ◯ Lack of easy access to technical information, flow charts and diagrams ◯ Lack of prioritization of guidelines ◯ Incomplete information (test results, patient history) ◯ Other:			

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E. Task Factors (continued)

E3. Was procedural or task design a factor in this event?
(Note: If unsure review the causes listed below)

◯ No
◯ Yes. Ifyes, why? Would correction eliminate reoccurrence? (if "Yes" tick "Root cause", if "No" tick "contributing factor":

Check all that apply → Then	**Describe the deviation and the cause**	**Check Appropriate Column**	
		Root Cause	Contributing factor
◯ Poorly designed (i.e. too complex; too much information; difficult to conceive or remember) ◯ Guidelines do not enable one to carry out the task in a timely manner ◯ Too many tasks to perform at the same time ◯ Contradicting tasks ◯ Staff do not agree with the 'task/procedure design' ◯ Stages of the task not designed so that each step can realistically be carried out ◯ Lack of direct or understandable feedback from the task ◯ Misrepresentation of information ◯ Inappropriate transfer of processes from other situations ◯ Inadequate audit, quality control, quality assurance built into the task design ◯ Insufficient opportunity to influence task/outcome where necessary ◯ Appropriate automation not available			

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◯ Other:			

F. Communication

F1. Was verbal, written, non-verbal communication, or communication management a factor in this event? (Note: If unsure review the causes listed below)

◯ No

◯ Yes. If yes, why? Would correction eliminate reoccurrence? (if "Yes" tick "Root cause", if "No" tick "contributing factor":

Check all that apply → Then	**Describe the deviation and the cause**	**Check Appropriate Column**	
		Root Cause	Contributing factor
Verbal ◯ Inappropriate tone of voice and style of delivery for situation ◯ Ambiguous verbal commands / directions ◯ Incorrect use of language ◯ Made to inappropriate person(s) ◯ Incorrect communication channels used **Written** ◯ Inadequate patient identification ◯ Records difficult to read ◯ All relevant records not stored together and accessible when required ◯ Records incomplete or not synchronized (e.g. Unavailability of patient management plans, patient risk assessments, etc.) ◯ Written information not circulated to all team members ◯ Communication not received ◯ Communications directed to the wrong people ◯ Lack of information to patients			

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◯ Lack of effective communication to staff of risks (alerts systems etc.) **Non-verbal** ◯ Body language issues (closed, open, body movement, gestures, facial expression) **Communication Management** ◯ Communication strategy and policy not defined/documented ◯ Ineffective involvement of patient/care provider in treatment and decisions ◯ Lack of effective communication to patients/ relatives/care providers of risks ◯ Lack of effective communication to patients about incidents (being open) ◯ Information from patient / care provider disregarded ◯ Ineffective communication flow to staff up, down and across ◯ Lack of measures for monitoring communication ◯ Patient/care provider issues not escalated to the supervisor ◯ Other:			

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G. Education & Training

G1. Was competence a factor in this event?
(Note: If unsure review the causes listed below)

◯ No
◯ Yes. Ifyes, why? Would correction eliminate reoccurrence? (if "Yes" tick "Root cause", if "No" tick "contributing factor":

Check all that apply ↓ Then →	**Describe the deviation and the cause**	**Check Appropriate Column**	
		Root Cause	Contributing factor
◯ Lack of knowledge ◯ Lack of skills ◯ Inexperience ◯ Inappropriate experience or lack of quality experience ◯ Unfamiliar task ◯ Lack of testing and assessment ◯ Ineffective communication flow to staff up, down and across ◯ Lack of measures for monitoring Communication ◯ Other:			

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G2. Was supervision a factor in this event? (Note: If unsure review the causes listed below)

◯ No

◯ Yes. If yes, why? Would correction eliminate reoccurrence? (if "Yes" tick "Root cause", if "No" tick "contributing factor":

Check all that apply → Then	Describe the deviation and the cause	Check Appropriate Column	
		Root Cause	Contributing factor
◯ Inadequate supervision ◯ Lack of / inadequate mentorship ◯ Training results not monitored/acted upon ◯ Other:			

G3. Was availability/accessibility a factor in this event? (Note: If unsure review the causes listed below)

◯ No

◯ Yes. If yes, why? Would correction eliminate reoccurrence? (if "Yes" tick "Root cause", if "No" tick "contributing factor":

Check all that apply → Then	Describe the deviation and the cause	Check Appropriate Column	
		Root Cause	Contributing factor
◯ Training needs analysis not conducted/acted upon ◯ On the job training unavailable or inaccessible ◯ Emergency training unavailable or inaccessible ◯ Team training unavailable or inaccessible ◯ Core skills training unavailable or inaccessible ◯ Refresher courses unavailable or inaccessible ◯ Other:			

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G4. Was appropriateness a factor in this event? (Note: If unsure review the causes listed below)

◯ No

◯ Yes. If yes, why? Would correction eliminate reoccurrence? (if "Yes" tick "Root cause", if "No" tick "contributing factor":

Check all that apply → Then	Describe the deviation and the cause	Check Appropriate Column	
		Root Cause	Contributing factor
◯ Inappropriate content ◯ Inappropriate target audience ◯ Inappropriate style of delivery ◯ Time of day provided inappropriate ◯ Other:			

H. Team Factors

H1. Did role congruence contribute to this event? (Note: If unsure review the causes listed below)

◯ No

◯ Yes. If yes, why? Would correction eliminate reoccurrence? (if "Yes" tick "Root cause", if "No" tick "contributing factor":

Check all that apply → Then	Describe the deviation and the cause	Check Appropriate Column	
		Root Cause	Contributing factor
◯ Lack of shared understanding ◯ Role + responsibility definitions misunderstood/not clearly defined ◯ Other:			

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H2. Was leadership a factor in this event? (Note: If unsure review the causes listed below)

◯ No

◯ Yes. If yes, why? Would correction eliminate reoccurrence? (if "Yes" tick "Root cause", if "No" tick "contributing factor":

Check all that apply → Then	Describe the deviation and the cause	Check Appropriate Column	
		Root Cause	Contributing factor
◯ Ineffective leadership – clinically ◯ Ineffective leadership – managerially ◯ Lack of decision making ◯ Inappropriate decision making ◯ Untimely decision making (delayed) ◯ Leader poorly respected ◯ Other:			

H3. Did support and cultural factors contributed to this event? (Note: If unsure review the causes listed below)

◯ No

◯ Yes. If yes, why? Would correction eliminate reoccurrence? (if "Yes" tick "Root cause", if "No" tick "contributing factor":

Check all that apply → Then	Describe the deviation and the cause	Check Appropriate Column	
		Root Cause	Contributing factor
◯ Lack of support networks for staff ◯ Inappropriate level of assertiveness ◯ Negative team reaction(s) to adverse events ◯ Negative team reaction to conflict ◯ Negative team reaction to newcomers ◯ Routine violation of rules/regulations ◯ Lack of team openness / communication with colleagues ◯ Inadequate inter-professional challenge			

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◯ Failure to seek support ◯ Failure to address / manage issues of competence (whistle blowing) ◯ Other:			

I. Organizational Factors

I1. Was the organizational structure a factor in this event? (Note: If unsure review the causes listed below)

◯ No

◯ Yes. If yes, why? Would correction eliminate reoccurrence? (if "Yes" tick "Root cause", if "No" tick "contributing factor":

Check all that apply ↓ Then →	**Describe the deviation and the cause**	**Check Appropriate Column**	
		Root Cause	Contributing factor
◯ Hierarchical structure / governance structure not conducive to discussion, problem sharing, etc. ◯ Tight boundaries for accountability and responsibility ◯ Professional isolation ◯ Clinical versus the managerial model ◯ Inadequate maintenance ◯ Lack of robust Service level agreements / contractual arrangements ◯ Inadequate safety terms and conditions of contracts ◯ Not safety driven ◯ Other:			

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I2. Were externally imported risks a factor in this event? (Note: If unsure review the causes listed below)

◯ No

◯ Yes. If yes, why? Would correction eliminate reoccurrence? (if "Yes" tick "Root cause", if "No" tick "contributing factor":

Check all that apply → Then	**Describe the deviation and the cause**	**Check Appropriate Column**	
		Root Cause	Contributing factor
◯ Unexpected adverse impact of national policy/guidance (from Ministry of Health) ◯ Locum policy and usage ◯ Contractors related problem ◯ Lack of service provision ◯ Bed occupancy levels (unplanned bed opening/closures) ◯ Other:			

I3. Was safety culture of the organization a factor in this event? (Note: If unsure review the causes listed below)

◯ No

◯ Yes. If yes, why? Would correction eliminate reoccurrence? (if "Yes" tick "Root cause", if "No" tick "contributing factor":

Check all that apply → Then	**Describe the deviation and the cause**	**Check Appropriate Column**	
		Root Cause	Contributing factor
◯ Inappropriate safety / efficiency balance ◯ Poor rule compliance ◯ Lack of risk management plans ◯ Inadequate leadership example (e.g. visible evidence of commitment to safety) ◯ Inadequately open culture to allow appropriate communication ◯ Inadequate learning from past incidents ◯ Incentives for 'at risk'/'risk taking' behaviors			

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◯ Acceptance / toleration of inadequate adherence to current practice ◯ Ignorance / poor awareness of inadequate adherence to current practice ◯ Disempowerment of staff to escalate issues or take action ◯ Other:			

J. Clinical Management

J1. Was any of the following a factor in this event?
◯ No
◯ Yes. If yes, why? Would correction eliminate reoccurrence? (if "Yes" tick "Root cause", if "No" tick "contributing factor":

Check all that apply	Describe the Deviation and the Cause	Check Appropriate Column	
		Root Cause	Contributing Factor
◯ History and physical within 24 hours of admission ◯ Appropriateness, timeliness, and completeness of medical record documentation ◯ Timely ordering of diagnostic tests ◯ Choice of diagnostic tests ◯ Timeliness of diagnosis ◯ Appropriateness of diagnosis ◯ Appropriateness of treatment ◯ Timing of treatment initiation ◯ Adequacy of procedure techniques ◯ Appropriateness of medication ordering and monitoring of effectiveness			

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◯ Addressing abnormal results of diagnostic tests ◯ Recognition and communication of critical clues to patient condition during a period of deterioration ◯ Timely initiation of appropriate action during a period of clinical deterioration ◯ Medical / Surgical Complication ◯ Judgment Error ◯ Error in treatment ◯ Inadequate treatment ◯ Error in Diagnosis ◯ Delay in treatment ◯ Negligence ◯ Other:			

Please select as applicable

- The case related to Sepsis
- The case related to VTE
- The case related to Diabetes
- The case related to Airway management
- The case related to CPR management
- The case related to medication
- The case related to medical Equipment

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Appendix 3 - Action Hierarchy

Action Strength	Action Category	Example
Stronger Actions (These tasks require less reliance on humans to remember to perform the task correctly)	Architectural/physical plant changes	Replace revolving doors at the main patient entrance into the building with powered sliding or swinging doors to reduce patient falls.
	New devices with usability testing	Perform heuristic tests of outpatient blood glucose meters and test strips and select the most appropriate for the patient population being served.
	Engineering control (forcing function)	Eliminate the use of universal adaptors and peripheral devices for medical equipment and use tubing/fittings that can only be connected the correct way (e.g., IV tubing and connectors that cannot physically be connected to sequential compression devices [SCDs]).
	Simplify process	Remove unnecessary steps in a process.
	Standardize on equipment or process	Standardize the make and model of medication pumps used throughout the institution. Use bar coding for medication administration.
	Tangible involvement by leadership	Participate in unit patient safety evaluations and interact with staff; support the RCA^2 process (root cause analysis and action); purchase needed equipment; ensure staffing and workload are balanced.
Intermediate Actions	Redundancy	Use two RNs to independently calculate high-risk medication dosages.
	Increase in staffing/decrease in workload	Make float staff available to assist when workloads peak during the day.
	Software enhancements, modifications	Use computer alerts for drug-drug interactions.
	Eliminate/reduce distractions	Provide quiet rooms for programming PCA pumps; remove distractions for nurses when programming medication pumps.
	Education using simulation-based training, with periodic refresher sessions and observations	Conduct patient handoffs in a simulation lab/environment, with after action critiques and debriefing.
	Checklist/cognitive aids	Use pre-induction and pre-incision checklists in operating rooms. Use a checklist when reprocessing flexible fibre optic endoscopes.
	Eliminate look- and sound-alikes	Do not store look-alikes next to one another in the unit medication room.
	Standardized communication tools	Use read-back for all critical lab values. Use read-back or repeat-back for all verbal medication orders. Use a standardized patient handoff format.

	Enhanced documentation, communication	Highlight medication name and dose on IV bags.
Weaker Actions (these tasks require more reliance on humans to remember to perform the task correctly)	Double checks	One person calculates dosage, another person reviews their calculation.
	Warnings	Add audible alarms or caution labels.
	New procedure/ memorandum/policy	Remember to check IV sites every 2 hours.
	Training	Demonstrate correct usage of hard-to-use medical equipment.

Reference: Action Hierarchy levels and categories are based on *Root Cause Analysis Tools*, VA National Center for Patient Safety, http://www.patientsafety.va.gov/docs/joe/rca_tools_2_15.pdf. Examples are provided here.
Source: National Patient Safety Foundation. *RCA^2 Improving Root Cause Analyses and Actions to Prevent Harm*. Boston, MA: National Patient Safety Foundation; 2015. Reproduced with permission.

Recommendations

SEQ	Recommendations	Action Due Date	Strength of Action	Responsibility	Measures of Effectiveness

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End of Report

Chairperson of Task Force	
Name: _____	
Designation: _____	
Signature: _____	**DATE:** _____

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Appendix 4: Sentinel Event Categories

1. Abduction of any patient (Newborn/Infant/Child/Adult) receiving care within a healthcare facility

Event Description:
This event is intended to capture all incidents when patients (live or dead) of any age are abducted from a healthcare facility regardless of whether severe temporary harm, permanent harm, or death occurred or not.

Inclusion:
- Abduction cases for any patients (live or dead), of any age group and health conditions (i.e., regardless of a patient's health condition) whether under care or receiving care within a healthcare facility's premises/campus.

Exclusion:
- Areas outside of the premises/campus of a healthcare facility.
- Health care facility visitors and patients' companions.
- Patients present within the premises/campus of a healthcare facility but not yet under Medical care.

2. Discharge or handing of a newborn or an infant to the wrong family

Event Description:
This event is intended to capture all cases where a newborn or an infant (Alive or dead) was discharged or handing to the wrong parent/legal guardian regardless of whether severe temporary harm, permanent harm, or death occurred or not.
Newborn: Birth to 29 days.[1]
Infant: A young baby, from 29 days to 12 months of age

Inclusion:
- All incidents where a newborn or an infant is discharged or not discharged home (handling) to the wrong parent/legal guardian.

Exclusion:
- None.

3. Discharge of a Minor or Incapacitated Patient to an unauthorized person

Event Description:
This event is intended to capture all cases where a minor or Incapacitated patient was discharged to an unauthorized parent/legal guardian regardless of whether death, permanent harm, or severe, temporary harm has occurred or not.
Minor age: 18 years and below.[2]
Incapacitated Patient: Incapacity is the clinical state in which a patient is unable to participate in a meaningful way in medical decisions.[3]

Inclusion:
- All cases where a minor or incapacitated patient was discharged to an unauthorized parent/legal guardian

Exclusion:
- None.

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4. Suicide, attempted suicide, or self-harm (Para suicide) of any patient in a healthcare setting or within 72 hours of discharge

Event Description:
This event is intended to capture all cases of suicide, attempted suicide, or self-harm that results in severe temporary harm, permanent harm, or death while being cared for in a healthcare setting or within 72 hours of discharge, including from the hospital's emergency department (ED) & OPD.

Inclusion:
- Any Suicide
- Any Attempted Suicide (para suicide)
- Any self-harm resulting in severe temporary harm, permanent harm, or death
- Inside or within premises
- Within 72 hours of discharge, including from the hospital's emergency department (ED) and OPD, or in-patient.

Exclusion:
- Patients present within a healthcare-facility but not receiving care, e.g., suicide, attempted suicide or self-harm in the healthcare facility restroom prior to checking in for care.
- Watcher and visitor

5. Staff Suicide, attempted suicide, or self-harm that results in severe temporary harm, permanent harm, or death.

Event Description:
This event is intended to capture all cases of suicide, attempted suicide, or self-harm those results in severe temporary harm, permanent harm, or death

Inclusion:
- Any staff Suicide, including contractors and sub-contractors' staff
- Any staff Attempt Suicide regardless successful or not
- Any staff self-harm result in severe temporary harm, permanent harm or death
- Inside or within premises include housing.

Exclusion:
None

6. Invasive diagnostic or therapeutic procedure or surgery, on the wrong patient, wrong site or side, wrong implant

Event Description:
This event is intended to capture all surgical/invasive diagnostic or therapeutic procedures performed, intended to be performed or discovered after anesthesia on the wrong patient~~s~~, wrong site or side, wrong implant or wrong procedure regardless of whether severe temporary harm, permanent harm, or death has occurred or not.

Inclusion:
- All surgical/invasive diagnostic or therapeutic procedures performed, intended to be performed or discovered after anesthesia and before surgery on the wrong patient~~s~~, wrong site or side, wrong implant or wrong procedure regardless of whether severe temporary harm, permanent harm, or death has occurred or not.
- Severe temporary harm, permanent harm, or death associated with the use of incorrectly positioned Oro or Nasogastric tube
- Within or outside Operating rooms including recovery rooms.
- General, local, regional anesthesia
- Dental procedures.

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Exclusion:
- None

7. Fertilizing wrong sperm to wrong ovum, or implant wrong embryo to wrong mother, or unexpected damage to embryos, sperm, eggs, or frozen tissue which is underwent fertilization in infertility centers

Event Description:
This event is intended to capture where fertilizing wrong sperm to wrong ovum, or implant wrong embryo to wrong mother or unexpected damage to embryos, sperm, eggs, or frozen tissue, which is in fertilization in infertility centers

Inclusion:
- All incidents with fertilizing wrong sperm to wrong ovum, or implant wrong embryo to wrong mother
- All incidents with unexpected damage to embryos, sperm, eggs, or frozen tissue in fertilization and infertility centers

Exclusion
None

8. Administration of incompatible ABO, Non-ABO of blood/ blood products, or transplantation of incompatible organs

Event Description:
This event is intended to capture cases involving the unintentional administration of incompatible ABO, non-ABO of blood/blood products, or transplantation of incompatible organs regardless of whether severe temporary harm, permanent harm, or death has occurred or not.

Inclusion:
- All cases involving the unintentional administration of incompatible ABO, non-ABO of blood/blood products, or transplantation of incompatible organs.

Exclusion:
- None

9. Unintended retention of a foreign object in a patient after invasive procedure, including surgery

Event Description:
This event is intended to capture all cases involving the unintended retention of a foreign object in a patient after surgery or other invasive procedure regardless of whether severe temporary harm, permanent harm, or death has occurred or not.

Inclusion:
- All cases involving the unintended retention of a foreign object in a patient, regardless of whether the retained object was discovered within a healthcare facility during hospitalization post-procedure or post-discharge.
- Any subject item such as swabs, needles, instruments, and guidewires.

Exclusion:
- Any object left for medical reasons in a patient, e.g., sutures, stents, implants, and medical devices

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10. Unexpected Death of a full-term Newborn

Event Description:
This event is intended to capture all unexpected Peri-natal death, no congenital anomalies in full term (Gestational Age 37 weeks and above) newborn having a birth weight equal to or greater than 2,500 grams.
Newborn: from birth to 28 days old

Inclusion:
- All cases include the unanticipated intrauterine fetal death (IUFD) whenever age of pregnancy 37 week and above

Exclusion:
- The death of a "term" newborn was related to congenital abnormalities.
- Pregnancies resulting in fetal demise before 37 weeks of gestation.
- Terminations of pregnancy for life-limiting fetal anomalies, or inductions of labor for provable premature rupture of membranes.

11. Rape cases encountered within the premises/campus of a healthcare facility.

Event Description:
This event is intended to capture all cases of rape of a patient, staff member, licensed independent practitioner, visitor, or vendor within a healthcare facility.

Inclusion:
- All rape cases encountered within the premises/campus of a healthcare facility.
- Vulnerable patient group such as comatose, underage, unconscious or bedridden found to be pregnant while she is under the care of the healthcare facility

Exclusion:
- None

12. Assault or homicide of any patient receiving care, treatment, and services at the health care facility setting

Event Description:
This event is intended to capture all assault or homicide cases for patients within the premises/campus of a healthcare facility that led to severe temporary harm, permanent harm, or death.
Assault: Intentional behavior that harms another person physically, including sexual assault[4]

Inclusion:
- All assault or homicide cases of patients within the premises/campus of a healthcare facility.

Exclusion:
- None

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13. Assault or homicide of Visitor or Watcher receiving care, treatment, and services at the healthcare facility setting

Event Description:
This event is intended to capture all assault or homicide cases for visitor or watcher within the premises/campus of a healthcare facility that led to severe temporary harm, permanent harm, or death by an employee or contractors.
Assault: Intentional behavior that harms another person physically, including sexual assault[4]

Inclusion:
- All assault or homicide cases of visitor or watcher within the premises/campus of a healthcare facility by an employee or contractors.

Exclusion:
- Assault by another visitor or watcher.

14. Physical and Psychological violence, or homicide of a staff member, or vendor at the healthcare facility setting

Event Description:
This event is intended to capture all physical and psychological violence and homicide cases for staff members, or vendors within the premises/campus of a healthcare facility that led to severe temporary harm, permanent harm, or death.

Physical violence: The use of physical force against another person or group that results in physical, sexual or psychological harm. It includes among others, beating, kicking, slapping, stabbing, shooting, pushing, biting and pinching. [4]
Psychological violence: Intentional use of power, including threat of physical force, against another person or group, that can result in harm to physical, mental, spiritual, moral or social development. It includes verbal abuse, bullying/mobbing, harassment, threats and racism.

Inclusion:
- All assault and homicide cases of staff members, or vendors within the premises/campus of a healthcare facility.

Exclusion:
- None

15. Fire, flame, unanticipated smoke, or flashes occurring within a healthcare facility

Event Description:
This event is intended to capture all fire, flame, unanticipated smoke, or flashes that occur within a healthcare facility regardless of whether severe temporary harm, permanent harm, or death occurred or not.

Inclusion:
- Healthcare facility housing
- Fire, flame, unanticipated smoke, or flashes because of hospital supplied devices to home healthcare client.
- All fire, flame, unanticipated smoke, or flashes that occur within a healthcare facility during patient care or affecting hospital property.

Exclusion:
- Anticipated smoke

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Event Description:
This event is intended to capture all cases associated with a patient leaving a healthcare facility without the knowledge/authorization (absconded) of the healthcare facility staff that led to severe temporary harm, permanent harm, or death.

Inclusion:
- All patients who leave a healthcare facility (including emergency care) while being cared for without the healthcare facility staff's knowledge/authorization.

Exclusion:
- If the death not related to patient condition such as accident

16. Medication error leading to severe temporary harm, permanent harm, or death.

Event Description:
This event is intended to capture all medication error cases resulting in severe temporary harm, permanent harm, or death, such as errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong preparation, or wrong route of administration.

Inclusion:
- Medication errors include severe temporary harm, permanent harm, or death associated with:
  - Administration of the wrong dose, including over or under-dosing.
  - Administration of a medication to a patient with a known allergy to the drug or one of its components, the failure to check/review the patient's allergies before administration, or the failure to record/retrieve a patient's allergy information before administration.
  - Drug interactions or contraindications with known potential risk.
  - Failure to administer prescribed medications, e.g., missed doses or missed medication.
  - Wrong route of administration.

Exclusion:
- None

17. Patient severe temporary harm, permanent harm, or death associated with intravascular air embolism

Event Description:
This event is intended to capture all cases where patients' severe temporary harm, permanent harm, or death was associated with intravascular air embolism.

Inclusion:
- High-risk procedures, including but not limited to procedures involving the head and neck, vaginal delivery and cesarean section, spinal instrumentation procedures, and liver transplantation.
- Low-risk procedures, including those related to the placement of infusion lines in a vascular space.

Exclusion:
- Neurosurgical procedures, where surgery was performed in a position that puts the head above the heart to reduce venous pressure, e.g., sub-occipital craniotomy.

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18.Patient severe temporary harm, permanent harm, or death as a result of medical device breakdown or failure when in use

Event Description:
This event is intended to capture all cases of patient severe temporary harm, permanent harm, or death as a result of medical devices breakdown or failure within healthcare facilities or dispensed by health care facility as home care devices.

Inclusion:
- All medical devices.

Exclusion:
- None.

19.Unexpected building collapse, or malfunctioning structure or overturning of any healthcare facility load bearing part of any lift or lifting equipment when in use or during installation

Event Description:
This event is intended to capture all cases of unexpected collapse of healthcare facility building, structure (standing, under construction, or alteration) or overturning of lifting equipment regardless of whether severe temporary harm, permanent harm, or death occurred or not. Malfunctioning structure (auto door, elevator etc.,) within the premises, which result in severe temporary harm, permanent harm, or death, this may include harm due to malfunctioning of auto doors or elevators**.**

Inclusion:
- All buildings within the premises/campus of a healthcare facility, including structures, under construction, alteration or standing.
- All building or overturning of lifting equipment within the premises/campus of a healthcare facility

Exclusion:
- None

20.Transfusing/ transplantation of contaminated blood, blood products, organ or tissue or transmission of disease as a result of using contaminated instruments or equipment provided by the healthcare facility

Event Description:
This event is intended to capture all cases of disease transmission associated with the infusion of contaminated blood, blood products, organs, or tissues and all cases of disease transmission after using contaminated devices, instruments, or equipment regardless of the source of contamination.

Inclusion:
- All cases of transfusing/transplantation of contaminated blood, blood products, organs, tissues, or implants.
- All cases of disease/infection transmission associated with the infusion of contaminated blood, blood products, organs, or tissues
- Inpatients and Ambulatory care services.

Exclusion:
None

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21.Death or serious disability associated with failure to manage/identify neonatal hyperbilirubinemia

Event Description:
This event is intended to capture all cases when death or serious disability is associated with failure to manage/identify neonatal hyperbilirubinemia (bilirubin > 30 milligrams/deciliter).

Inclusion:
- All death or disability cases (e.g., Kernicterus) resulted from failure to identify/re-assess or manage neonatal hyperbilirubinemia.

Exclusion:
- None

22. Delivery of radiotherapy to the wrong body region or dose exceeds more than 25% of the total planned radiotherapy dose

Event Description:
This event is intended to capture all cases where radiotherapy dose was delivered to the wrong body region or when the dose exceeds more than 25% of the total planned dose.

Inclusion:
- This event includes radioisotope therapy and radiation producing machines.
- This event includes staff exposure

Exclusion
- None

23.Patient severe temporary harm, permanent harm, or death as a result of patient fall

Event Description:
This event is intended to capture patient severe temporary harm, permanent harm, or death associated with patient fall while being cared for within a healthcare facility.

Inclusion:
- Patients admitted within a healthcare facility, including Day Care Unit, emergency department, OPD and endoscopy and bronchoscopy unit.

Exclusion:
- None

24. Patient severe temporary harm, permanent harm, or death associated with administration/ connection of the wrong medical gas

Event Description:
This event is intended to capture all cases of patient severe temporary harm, permanent harm, or death associated with the administration/connection of the wrong medical gas.

Inclusion:
- Incidents where medical gas connected to a patient contain no gas or the wrong gas.

Exclusion:
- None

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25.System failure leading to service interruption and total evacuation outside healthcare facility

Event Description:
This event is intended to capture all Systems failure leading to service interruption and required total evacuation outside health care facility regardless of patient harm as outcome.

Inclusion:
- Include financially affected
- Medical gas system, Water system, Electrical, Security system, Safety system and Information health care system.

Exclusion:
- Horizontal and vertical evacuation within the health care facility

26.Unexpected death

Event Description:
This event is intended to capture all death unrelated to the natural course of the patient's illness or underlying condition

Inclusion:
- All Unexpected death in all age group (except Newborn: from birth to 28 days), within the healthcare facilities this include and not limited to waiting area, OPD, ED, OR and inpatient unit.
- Unexpected death associated with the transport/transfer of patients either within the institute or between healthcare facilities.
- Patient death for patient with (ASA I & II) during or within 24-48 hours of surgery/ procedure sedation, (ASA I & II, American Society Anesthesiologists level 1 and 2 classification)
- Unexpected death of patient discharged within 72 hours from ED, OPD, Inpatient unit.
- Unexpected death of Cancer patient due to delayed diagnosis or mis diagnosis because of health care facilities system.

Exclusion:
None

27.Unexpected Loss of a limb or a function

Event Description:
This event is intended to capture all incidents of an unexpected loss of a limb or a function not related to natural course of the illness.

Inclusion:
- All loss of limb or a function which is not related to the natural course of the illness

Exclusion:
- None

28.Maternal death, permanent harm, or severe temporary harm

Event Description:
This event is intended to capture maternal death permanent harm, or severe temporary harm aggravated by pregnancy or its management during pregnancy within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy.

Inclusion:
▪ Death, permanent harm, or severe temporary harm related to any incidental causes aggravated by the pregnancy or its management.

Exclusion:
▪ Accidental cusses such as but not limited to motor vehicle accident.

29.MR damage or Patient or staff severe temporary harm, permanent harm, or death associated with introduction of a metallic object

Event Description:
This event is intended to capture all incident resulting in death, serious injury of patient, staff, or MR damage associated with introduction of a metallic object into MR.
Inclusion:
▪ All incident result in death, serious injury of patient or staff associated with introduction of a metallic object into MR.
▪ All incident resulting in MR damage or loss associated with introduction of a metallic object into MR.

Exclusion:
▪None

30. Loss or damage to specimen sample or tissue biopsy after invasive procedure

Event Description:
This event is intended to capture all incident resulting in loss or damage to specimen tissue or body sample after invasive procedure subjected to informed consent.

Inclusion:
▪ Lumbar Puncture sample after LP procedure
▪ Bone marrow specimen after bone marrow aspiration
▪ Tissue biopsy after endoscopy
▪ Fine needle aspiration

Exclusion:
▪ Loss of blood sample after intravenous cannulation
▪Loss of blood sample after central line insertion

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قائمة الأحداث الجسيمة في وزارة الصحة باللغة العربية

1- خطف (رضيع، طفل، بالغ) يتلقى الرعاية داخل منشآت الرعاية الصحية

وصف الحدث: أي حادثة خطف لمتلقي الرعاية داخل المنشأة الصحية سواء كان حي أو ميت في أي عمر كان. سواء أدى الخطف إلى ضرر بالغ مؤقت، ضرر مزمن أو وفاة أم لم يؤدي إلى ذلك أم لم يؤدي إلى ذلك.

يتضمن الحدث الجسيم: أي حادثة خطف لمتلقي الرعاية داخل المنشأة الصحية سواء كان حي أو ميت (رضيع، طفل، بالغ) بغض النظر عن حالته الصحية

يستثنى من الحدث الجسيم:

- حدوث الخطف في خارج أسوار المنشأة الصحية
- خطف الزوار والمرافقين
- مراجعي المنشأة الصحية اللذين لم يخضعوا للرعاية الطبية بعد ومراجعين العيادات الخارجية

2- تسليم المولود أو الرضيع إلى غير ذويه

وصف الحدث: أي حادثة تسليم لمولود أو رضيع إلى غير ذويه سواء كان حيا أو ميتا سواء أدى إلى ضرر بالغ مؤقت، ضرر مزمن أو وفاة أم لم يؤدي إلى ذلك.

المولود: منذ الولادة حتى 28يوم

الرضيع: من عمر 29يوم حتى 12 شهر

يتضمن الحدث الجسيم: سواء تم خروج المولود / الرضيع أو لم يتم إخراجه من المنشأة الصحية وتم تسليمه لغير ذويه /الوصي القانوني

يستثنى من الحدث: لا يوجد

3- تسليم المريض القاصر أو عاجز أو فاقد الإدراك لغير الوصي القانوني

وصف الحدث: أي حادثة تسليم لمريض قاصر أو عاجز أو فاقد الإدراك لغير الوصي القانوني وبغض النظر عن نتيجة هذا الحدث سواء أدى إلى وفاة أو ضرر شديد مؤقت أو دائم أو لم يؤدي إلى ذلك

القاصر: أقل من سن 18 سنة

العاجز أو فاقد الإدراك: العجز في الحالة الذهنية الإدراكية مما يؤدي إلى عدم القدرة على اتخاذ القرارات

يتضمن الحدث: أي حادثة تسليم لمريض قاصر أو فاقد الإدراك لغير الوصي القانوني وبغض النظر عن نتيجة هذا الحدث سواء أدى إلى وفاة أو ضرر شديد مؤقت أو دائم أو لم يؤدي إلى ذلك

ويستثنى الحدث الجسيم: لا يوجد

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4- الانتحار، محاولة الانتحار أو إيذاء النفس الذي ينتج عنه ضرر بالغ مؤقت، ضرر مزمن أو وفاة أثناء تلقي الرعاية في بيئة الرعاية الصحية أو خلال 72 ساعة من الخروج

وصف الحدث: الانتحار، محاولة الانتحار أو إيذاء النفس الذي ينتج عنه ضرر بالغ مؤقت، ضرر مزمن أو وفاة أثناء تلقي الرعاية في بيئة الرعاية الصحية أو خلال 72 ساعة من الخروج، بما في ذلك قسم الطوارئ أو العيادات الخارجية.

يتضمن الحدث

- الانتحار
- محاولة الانتحار
- إيذاء للنفس أدى إلى ضرر بالغ مؤقت، ضرر مزمن أو وفاة
- داخل أسوار المنشأة الصحية
- خلال 72 ساعة من ساعة الخروج بما في ذلك الخروج من قسم الطوارئ أو العيادات الخارجية

ويستثنى من الحدث الجسيم:

مراجعي المنشأة الصحية اللذين لم يخضعوا للرعاية الطبية بعد

المرافقين والزوار

5- الانتحار، محاولة الانتحار أو إيذاء النفس الذي ينتج عنه ضرر بالغ مؤقت، ضرر مزمن أو وفاة الموظف أو العامل في المنشأة الصحية

وصف الحدث: الانتحار، محاولة الانتحار أو إيذاء النفس الذي ينتج عنه ضرر بالغ مؤقت، ضرر مزمن أو وفاة الموظف أو العامل في المنشأة الصحية

يتضمن الحدث الجسيم:

- الانتحار
- محاولة الانتحار
- أي إيذاء للنفس أدى إلى ضرر بالغ مؤقت، ضرر مزمن أو وفاة
- داخل أسوار المنشأة الصحية ويتضمن السكن

ويستثنى من الحدث الجسيم: لا يوجد

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6- إجراء عمليات جراحية أو تشخيصيه أو علاجيه لمريض خاطئ أو إجراء خاطئ أو موقع خاطئ للعملية الجراحية أو زراعه خاطئة

وصف الحدث: الحدث يلتقط جميع الأحداث الخاصة بالتدخلات الجراحية التي تم إجراءها أو اكتشفت بعد التخدير للمريض الخاطئ أو مكان الجراحي الخاطئ أو زراعة في مكان خاطئ مما نتج عنه ضرر بالغ مؤقت، ضرر مزمن أو وفاة

يتضمن الحدث الجسيم:

- جميع الأحداث الخاصة بالتدخلات الجراحية التي تم إجراءها أو اكتشفت بعد التخدير للمريض الخاطئ أو مكان الجراحي الخاطئ أو زراعة في مكان خاطئ مما نتج عنه ضرر بالغ مؤقت، ضرر مزمن أو وفاة
- وفاة أو ضرر شديد مؤقت أو دائم ناتج عن وضع أنبوبة التغذية عن طريق الأنف في المكان الخاطئ
- 3-داخل أو خارج غرفة العمليات
- 4 - التخدير بأنواعه موضعي، عام
- 5-إجراءات طب الأسنان

ويستثنى من الحدث الجسيم: لا يوجد

7- إخصاب الحيوانات المنوية للبويضة الخاطئة أو تنفيذها بشكل خاطئ (حقنها) للأم الخاطئة أو تلف غير متوقع للحيوانات المنوية أو البويضة أو الأجنة بعد التخصيب في مراكز العقم

وصف الحدث: إخصاب الحيوانات المنوية للبويضة الخاطئة أو تنفيذها بشكل خاطئ (حقنها) للأم الخاطئة أو تلف غير متوقع للحيوانات المنوية أو البويضة أو الأجنة بعد التخصيب التي تم تجميدها

يتضمن الحدث الجسيم: إخصاب الحيوانات المنوية للبويضة الخاطئة أو تنفيذها بشكل خاطئ (حقنها) للأم الخاطئة أو تلف غير متوقع للحيوانات المنوية أو البويضة أو الأجنة بعد التخصيب في مراكز العقم

ويستثنى من الحدث الجسيم: لا يوجد

8- إعطاء فصيلة دم غير متوافقة أو أحد مشتقات الدم أو زراعة أعضاء غير متوافقة

وصف الحدث الجسيم: الحدث يتضمن إعطاء فصيلة دم غير متوافقة أو أحد مشتقات الدم أو زراعة أعضاء غير متوافقة سواء نتج عنه ضرر بالغ مؤقت، ضرر مزمن أو وفاة أم لم ينتج عنه ذلك

يتضمن الحدث الجسيم: كل الحوادث والإجراءات المتعلقة بنقل دم أو مشتقاته أو عضو

ويستثنى من الحدث: لا يوجد

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9- نسيان غير مقصود لأدوات جراحية أو شاش في جسد المريض بعد إجراء جراحي أو إجراء تدخلي

وصف الحدث: نسيان غير مقصود لأدوات جراحية أو شاش في جسد المريض بعد إجراء جراحي أو تدخلي سواء نتج عنه ضرر بالغ مؤقت، ضرر مزمن أو وفاة أم لم ينتج عنه ذلك

يتضمن الحدث الجسيم:

- جميع الأحداث التي تتضمن نسيان غير مقصود لأدوات جراحية أو شاش في جسد المريض بعد إجراء جراحي سواء تم اكتشافها بعد العملية الجراحية أو بعد الخروج من المنشأة الصحية
- أي مادة غريبه عن الجسم وليست من ضمن الخطة العلاجية مثل الإبر، المسحات والشاش

ويستثنى من الحدث الجسيم: أي مادة تركت بغرض علاجي وضمن الخطة العلاجية

10- الوفاة الغير متوقعه لحديثي الولادة مكتمل النمو

وصف الحدث: يتضمن الحدث أي وفاة غير متوقعه لحديث الولادة أو الرضيع مكتمل النمو في الفترة المحيطة بالولادة (37 أسبوع وأكثر) وأن يكون المولود لا يعاني من عيوب خلقيه ووزنه عند الولادة يساوي أو أكثر من 2500 جم

المولود: من عمر الولادة حتى 29 يوم

يتضمن الحدث الجسيم: أن تكون الوفاة في الفترة المحيطة بالولادة يكون عمر الحمل (الجنين) 37 أسبوع وأكثر

ويستثنى من الحدث الجسيم:

- وجود عيوب خلقيه
- وفاة الجنين تحت 37 أسبوع
- إنهاء الحمل بسبب التشوهات الخلقية أو تحريض المخاض بسبب تمزق الأغشية المثبت

11- حالات الاغتصاب التي تم رصدها داخل أسوار المنشأة الصحية

وصف الحدث: حالات اغتصاب المريض أو موظف أو زائر أو عامل في المنشأة الصحية ويندرج تحت مؤسسة أخرى مرخصة

يتضمن الحدث الجسيم:

- كل حالات الاغتصاب داخل أسوار المنشأة
- حالات الاغتصاب لمرضى غير مدركين ذهنيا أو فاقدي الوعي

يستثنى من الحدث الجسيم: لا يوجد

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12- الاعتداء الذي يؤدي ضرر بالغ مؤقت، ضرر مزمن أو وفاة المريض الذي يتلقى الرعاية أو العلاج أو الخدمة الصحية داخل المنشأة الصحية

وصف الحدث: يتضمن الحدث كل الاعتداءات التي تؤدي إلى ضرر بالغ مؤقت، ضرر مزمن أو وفاة المريض الذي يتلقى الرعاية الصحية داخل المنشأة الصحية

يتضمن الحدث الجسيم: جميع حالات الاعتداء على المرضى داخل أسوار المنشأة

يستثنى من الحدث الجسيم: لا يوجد

13- الاعتداء الذي يؤدي إلى ضرر بالغ مؤقت، ضرر مزمن أو وفاة لزائر أو مرافق داخل المنشأة الصحية

وصف الحدث: يتضمن الحدث الاعتداء الذي يؤدي إلى ضرر بالغ مؤقت، ضرر مزمن أو وفاة لزائر أو مرافق داخل المنشأة الصحية

يتضمن الحدث الجسيم: كل الاعتداءات التي تؤودي إلى ضرر بالغ مؤقت، ضرر مزمن أو وفاة لزائر أو مرافق داخل المنشأة الصحية

يستثنى من الحدث الجسيم: الاعتداء من قبل مرافق أو زائر آخر

14- الاعتداء الذي يؤدي إلى ضرر بالغ مؤقت، ضرر مزمن أو وفاة لممارسين الصحيين أو الموظفين أو المتعاقدين عاملين في المنشأة الصحية ويندرج تحت مؤسسات أخرى داخل المنشأة الصحية

وصف الحدث: يتضمن الحدث كل الاعتداءات التي تؤودي إلى ضرر بالغ مؤقت، ضرر مزمن أو وفاة لممارسين الصحيين أو الموظفين أو المتعاقدين عاملين في المنشأة الصحية ويندرج تحت مؤسسات أخرى داخل المنشأة الصحية

العنف الجسدي: استخدام القوة الجسدية ضد شخص أو مجموعة أخرى ينتج عنه أذى جسدي أو جنسي أو نفسي. ويشمل ذلك الضرب والركل والصفع والطعن وإطلاق النار والدفع والعض والقرص

العنف النفسي: الاستخدام المتعمد للقوة، بما في ذلك التهديد باستخدام القوة الجسدية، ضد شخص ومجموعة أخرى، مما قد يؤدي إلى الإضرار بالتطور البدني أو العقلي أو ألأخلاقي أو الاجتماعي. وهي تشمل الإساءة اللفظية والتنمر؟ المهاجمة والمضايقة والتهديدات والعنصرية

يتضمن الحدث الجسيم: كل الاعتداءات التي تؤودي إلى ضرر بالغ مؤقت، ضرر مزمن أو وفاة الممارسين الصحيين أو الموظفين أو المتعاقدين عاملين في المنشأة الصحية ويندرج تحت مؤسسات أخرى داخل المنشأة الصحية

يستثنى من الحدث الجسيم: لا يوجد

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15- حريق، لهب أو دخان غير متوقع أو ومضات داخل المنشأة الصحية

وصف الحدث: يهدف الحدث لرصد كل ما يحدث داخل المنشأة من حريق، لهب أو دخان غير متوقع أو ومضات بغض النظر عن وجود وفاة أو ضرر شديد مؤقت أو دائم

يتضمن الحدث الجسيم:

- إسكان الموظفين في المنشأة الصحية
- حريق، لهب أو دخان غير متوقع ناتج عن الأجهزة الطبية المصروفة ضمن الخطة العلاجية من المنشأة الصحية للمرضى في منازلهم
- كل حريق، لهب أو دخان غير متوقع أو ومضات داخل المنشأة الصحية خلال تقديم الرعاية للمريض أو يؤثر على مرفق المستشفى

يستثنى من الحدث: الدخان المتوقع

16- الخروج الغير مصرح للمريض (الهروب) أثناء فترة الرعاية الصحية والمؤدية إلى ضرر بالغ مؤقت، ضرر مزمن أو وفاة

وصف الحدث: رصد جميع حالات إلى ضرر بالغ مؤقت، ضرر مزمن أو وفاة المرتبط بمغادرة المريض بدون علم وتصريح من مقدمي الرعاية

يتضمن الحدث الجسيم: جميع المرضى اللذين يغادرون المنشأة الصحية بما فيها الطوارئ بدون علم او تصريح من مقدمي الرعاية الصحية بما ذلك الخروج من الطوارئ

يستثنى من الحدث الجسيم: إذا كانت الوفاة أو الضرر غير متعلق بحالة المريض الصحية مثل الحوادث المرورية

17- الخطأ الدوائي الذي يؤدي إلى ضرر بالغ مؤقت، ضرر مزمن أو وفاة

وصف الحدث: رصد حالات الخطأ الدوائي الذي يؤدي إلى ضرر بالغ مؤقت، ضرر مزمن أو وفاة على سبيل المثال خطأ في اسم الدواء أو في الجرعة المعطاة أو خطأ في المريض أو خطأ في توقيت إعطاء الدواء أو خطأ في تحضير الدواء أو خطأ في طريقة إعطاء الدواء

يتضمن الحدث الجسيم: كل خطأ دوائي يؤدي إلى الوفاة أو الضرر الشديد المؤقت أو الدائم المتعلق ب:

- إعطاء جرعة دوائية خاطئة سواء كانت زائدة أو ناقصة عن الجرعة المحددة
- إعطاء دواء لمريض يعاني من حساسية معروفه لهذا الدواء او أحد مكوناته، عدم فحص حساسية المريض مسبقاً قبل إعطاء الجرعة أو عدم القدرة على الحصول على معلومات المريض السابقة أو توثيقها فيما يخص الحساسية الدوائية
- وجود تفاعلات دوائية أو موانع طبية محتملة مع وجود مخاطر معروفه
- عدم إعطاء الأدوية الموصوفة على سبيل المثال نسيان إعطاء الجرعة او الدواء الموصوف
- إعطاء الدواء بالطريقة الخطأ على خلاف الوصفة الطبية

يستثنى من الحدث الجسيم: لا يوجد

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18- وفاة المريض، الضرر الدائم أو المؤقت البالغ المرتبط بالانسداد الهوائي داخل الأوعية الدموية

وصف الحدث: كل الأحداث المتعلقة بوفاة المريض، الضرر الدائم أو المؤقت البالغ المرتبط بالانسداد الهوائي داخل الأوعية الدموية.

يتضمن الحدث الجسيم:

- جميع العمليات ذات الخطورة العالية: على سبيل المثال لا الحصر عمليات الرأس والرقبة، الولادات الطبيعية والقيصرية، تدخلات العامود الفقري الجراحية وزراعة الكبد
- جميع العمليات ذات الخطورة المنخفضة: التدخلات المتعلقة بوضع خطوط التسريب داخل الأوعية الدموية

يستثنى من الحدث الجسيم: العمليات الجراحية المختصة بالمخ والأعصاب وتتطلب وضعية معينة وهي وضع الرأس أعلى من القلب لتخفيف الضغط الوريدي

19- وفاة المريض أو الضرر الدائم أو المؤقت البالغ نتيجة توقف الجهاز الطبي أو تعطله عند استخدامه

وصف الحدث: كل الأحداث المتعلقة بوفاة المريض أو الضرر الدائم أو المؤقت الشديد نتيجة توقف الجهاز الطبي في المنشأة الصحية أو الأجهزة الطبية المصروفة كأجهزة رعاية طبية منزلية

يتضمن الحدث الجسيم: جميع الأجهزة والأدوات الطبية

يستثنى الحدث الجسم: لا يوجد

20- انهيار غير متوقع لمبنى أو هيكل المنشأة الصحية أو تعطل أحد مرافقها سواء كان (قائم، قيد الإنشاء، أو تحت التعديل) أو أي جزء تحميلي من مرافق الرعاية الصحية أو يحمل معدات الرفع الآلية عند الاستخدام أو أثناء البناء

وصف الحدث: انهيار غير متوقع لمبنى أو هيكل المنشأة الصحية (قائم، قيد الإنشاء، أو تحت التعديل) أو انهيار / سقوط غير متوقع لأي جزء تحميلي من مرافق الرعاية الصحية أو يحمل معدات الرفع الآلية عند الاستخدام أو أثناء البناء سواء أدى إلى ضرر بالغ مؤقت، ضرر مزمن أو وفاة أولم يؤدي إلى ذلك أو تعطل أحد مرافق المنشأة الصحية أو عطل في البنية (عطل في المصعد أو الباب الأتوماتيكي) وأدى إلى ضرر بالغ مؤقت، ضرر مزمن أو وفاة

يتضمن الحدث الجسيم:

جميع حوادث انهيار المباني أ المرافق داخل المنشأة الصحية سواء كانت تحت الإنشاء أو التعديل أو كانت قائمة

جميع حوادث الانهيار / السقوط الغير متوقع لأي جزء تحميلي من مرافق الرعاية الصحية أو يحمل معدات الرفع الآلية عند الاستخدام

يستثنى من الحدث: لا يوجد

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21- نقل الدم ومشتقاته أو زراعة العضو أو النسيج الملوث أو انتقال مرض معدي نتيجة لاستخدام أدوات أو معدات ملوثة مقدمة من منشأة الرعاية الصحية

وصف الحدث: يتضمن رصد جميع حالات انتقال المرض المرتبطة بنقل الدم الملوث ومشتقاته أو زراعة العضو أو النسيج الملوث أو انتقال مرض معدي نتيجة لاستخدام أدوات أو معدات ملوثة مقدمة من منشأة الرعاية الصحية بغض النظر عن مصدر التلوث

يتضمن الحدث الجسم:

- جميع حالات نقل الدم ومشتقاته والأعضاء والأنسجة الملوثة وزراعة الأجهزة العلاجية الملوثة
- جميع حالات انتقال المرض او العدوى
- حالات التنويم أو العيادات

يستثنى من الحدث الجسيم: لا يوجد

22- وفاة أو إعاقة بالغة نتيجة عدم القدرة في اكتشاف أو خلل في علاج الصفار عالي الخطورة لدى المواليد

وصف الحدث: يتضمن كل حدث وفاة أو إعاقة خطيرة نتيجة عدم القدرة في اكتشاف أو خلل في علاج الصفار عالي الخطورة لدى المواليد

يتضمن الحدث الجسيم: كل حدث وفاة أو إعاقة خطيرة نتيجة عدم القدرة في اكتشاف/ إعادة تقييم أو علاج الصفار عالي الخطورة لدى المواليد

يستثنى من الحدث الجسيم: لا يوجد

23- إعطاء الإشعاع العلاجي في المكان الخطأ من الجسم أو إعطاء جرعة تتجاوز 25% من الجرعة المطلوبة من الإشعاع العلاجي

وصف الحدث: يتضمن رصد جميع الحالات التي تم إعطاءها الإشعاع العلاجي في المكان أو الخطأ من الجسم أو إعطاء جرعة تتجاوز 25% من الجرعة المطلوبة من الإشعاع العلاجي

يتضمن الحدث الجسيم: كل حدث يتم فيها إعطاء الإشعاع العلاجي في المكان أو الخطأ من الجسم أو إعطاء جرعة تتجاوز 25% من الجرعة المطلوبة من الإشعاع العلاجي

يستثنى من الحدث الجسيم: لا يوجد

24- وفاة أو ضرر دائم أو مؤقت بالغ نتيجة سقوط المريض داخل منشأة الرعاية الصحية

وصف الحدث: يتضمن كل حدث وفاة أو ضرر دائم أو مؤقت بالغ نتيجة سقوط المريض أثناء الرعاية الصحية وداخل منشأة الرعاية الصحية

يتضمن الحدث الجسيم: كل المرضى الذين تم تنويمهم داخل المنشأة الصحية ويتضمن وحدة الرعاية اليومية، قسم الطوارئ، العيادات الخارجية ووحدة المناظير.

يستثنى من الحدث الجسيم: لا يوجد

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25- وفاة أو ضرر دائم أو مؤقت بالغ نتيجة خطأ في إعطاء الغازات الطبية أو توصيل الغازات الطبية بالخطأ

وصف الحدث: يتضمن كل حدث وفاة أو ضرر دائم أو مؤقت بالغ نتيجة خطأ في إعطاء أو توصيل الغازات الطبية

يتضمن الحدث الجسيم: كل حدث نتيجة خطأ في إعطاء الغازات الطبية أو توصيل الغاز وكان فارغ أو غاز خاطئ

يستثنى الحدث الجسيم: لا يوجد

26- فشل النظام مما يؤدي إلى انقطاع الخدمة والإخلاء الكامل إلى خارج منشأة الرعاية الصحية

وصف الحدث: رصد كل حدث نتيجة فشل النظام مما يؤدي إلى انقطاع الخدمة والإخلاء الكامل إلى خارج منشأة الرعاية الصحية سواء أدى إلى ضرر بالغ مؤقت، ضرر مزمن أو وفاة أم لم يؤدي إلى ذلك

يتضمن الحدث الجسيم:

- الخسائر المادية المترتبة على ذلك
- نظام الغازات الطبية، نظام المياه، النظام الكهربائي، النظام الأمني ونظام المعلوماتية الصحية

يستثنى من الحدث الجسيم: الأحداث التي يحدث فيها الإخلاء العامودي او الأفقي داخل المنشأة

27- وفاة غير متوقعه

وصف الحدث: رصد جميع الوفيات ة التي ليس لها علاقة بطبيعة المرض ومضاعفاته

يتضمن الحدث الجسيم:

- الوفاة الغير متوقعه لجميع الأعمار ماعدا عمر حديثي الولادة (من الولادة وحتى عمر 28 يوم) داخل منشأة الرعاية الصحية متضمنا وغير مقتصر على أماكن الانتظار، العيادات، الطوارئ، العمليات وأقسام التنويم
- وفاة غير متوقعه مرتبطة بالنقل / إيصال المريض داخل المنشأة او بين منشآت الرعاية الصحية
- وفاة المريض أثناء 24 الى 48 ساعة من الجراحة/ التخدير الإجرائي لمريض من التصنيف الأول او الثاني من تصنيفات التخدير
- وفاة غير متوقعه بعد خروج المريض من المنشأة الصحية خلال 72 ساعة سواء كان الخروج من التنويم أو أقسام الطوارئ أو العيادات
- وفاة غير متوقعه لمريض يعاني من السرطان نتيجة تأخر في التشخيص أو العلاج بسبب نظام الرعاية الصحية

يستثنى من الحدث الجسيم: لا يوجد

28- فقد عضو أو وظيفة غير متوقع

وصف الحدث: فقد عضو أو وظيفة عضو ليس له علاقة بطبيعة المرض

يتضمن الحدث الجسيم: كل حدث فيه فقد لعضو أو وظيفة عضو

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يستثنى من الحدث الجسيم: لا يوجد

29- وفيات الأمهات

وصف الحدث الجسيم: رصد لوفاة مرتبط بالحمل أو العلاج المقدم اثناء الحمل وخلال 42يوم من انتهاء الحمل بغض النظر عن فترة الحمل أو مكانه

يتضمن الحدث الجسيم: كل حدث وفاة أم نتيجة تفاقم الاعراض خلال فترة الحمل أو علاجه.

يستثنى من الحدث الجسيم:

وفاة الأم الحامل نتيجة الحوادث المرورية

30- تلف الرنين المغناطيسي المرتبط بإدخال جسم معدني

وصف الحدث: رصد كل حدث يؤدي إلى ضرر بالغ مؤقت، ضرر مزمن أو وفاة للمريض أو أحد العاملين نتيجة دخول جسم معدني لغرفة الرنين المغناطيسي

يتضمن الحدث الجسيم:

1-كل الأحداث المؤدية إلى ضرر بالغ مؤقت، ضرر مزمن أو وفاة للمريض أو أحد العاملين نتيجة دخول جسم معدني لغرفة الرنين المغناطيسي

2- كل الأحداث المؤدية إلى تلف في جهاز الرنين المغناطيسي نتيجة دخول جسم معدني لغرفة الرنين المغناطيسي

يستثنى من الحدث الجسيم: لا يوجد

31- قدان أو تلف عينة أو خزعة الأنسجة بعد تدخل إجرائي

وصف الحدث: رصد كل حدث له علاقة بفقدان او تلف عينه أو خزعة بعد تدخل إجرائي احتاج توقيع على وافقة الإجراء

يتضمن الحدث الجسيم:

- عينة سائل النخاع الشوكي
- عينة نخاع العظم
- خزعة بعد المنظار
- خزعات الخلايا بالإبرة

يستثنى من الحدث الجسيم:

- فقدان أو تلف عينة الدم بعد سحب العينات الوريدية الطرفية
- فقدان أو تلف عينة بعد سحب عينات الوردية المركزية