1. INCIDENT REPORTING

It is defined as written or verbal reporting of any event in the process reporting of patient care that is inconsistent with the deserved patient outcome or routine operations of the healthcare facility.

2. TYPES OF INCIDENT:

NO HARM: The error is not recognized and the deed is done but fortunately for the healthcare professional, the expected adverse event does not occur.

NEAR - MISS: A near-miss is an unplanned event that did not result in injury, illness, or damage -- but had the potential to do so. Errors that did not result in patient harm, but could have, can be categorized as near misses. A near-miss is defined when an error is realized just in the nick of time and abortive action is instituted to cut short its translation.

ADVERSE EVENT: An injury related to medical management, in contrast to complications of disease. Medical management includes all aspects of care, including diagnosis and treatment, failure to diagnose or treat, and the systems and equipment used to deliver care. Adverse events may be preventable or Non preventable. (WHO Draft Guidelines for Adverse Event Reporting and Learning Systems)

SENTINEL EVENT: A relatively infrequent, unexpected incident, related to system or process deficiencies, which leads to death or major and enduring loss of function for a recipient of healthcare services.

Major and enduring loss of function refers to sensory, motor, physiological, or psychological impairment not present at the time services were sought or begun. The impairment lasts for a minimum period of two weeks and is not related to an underlying condition.

LIST OF REPORTABLE EVENTS BUT NOT LIMITED TO			
Sl. No.	**Reportable Events**	**Description**	**Responsible Person for Reporting** (Any staff notices the event can report the incident)
Patient Safety			
1.	Patient Fall	During the hospital stay, either due to slipper floor, from the cot, while shifting	Assigned staff, Head Nurse, Nursing supervisor, PCS staff OPD staff Other staff who noticed
2.	Medication Error, Prescription,	Legible prescriptions, covers without details of medicines, medicines wrongly entered inpatient medical record, index or medication chart, wrong medicine dispensed from pharmacy, wrong route, dose, time frequency, patient or drug administered, emission or omission of drugs when patient is changed from one setting to the other. Extravasation of drug	Assigned staff, Head Nurse, Nursing Supervisor, Doctors Clinical Pharmacist, Pharmacist
3.	Other injuries occurred within the hospital setting	Burns, Cut injury due to fan or any machine, structural defect, while preparation for surgery, collision	Assigned staff, Head Nurse, Nursing supervisor, Any staff
4.	Transition injury	Injury while transportation of the patient in Wheelchairs / trolleys / bed without belts. Tucked blanket, raised rails.	Assigned staff, Head Nurse, Nursing supervisor, Nursing assistant, Attenders
5.	Identity error	Wrong patient, Wrong MID No., No ID band, No two identifiers, This leads to severe procedural or treatment error	Assigned staff, Head Nurse, Nursing supervisor and other staff who notices.

6.	HAI (Bedsore, SSI, VAP UTI, Central line infection, MRSA, Hospital Acquired communicable disease)	Noncompliance to Aseptic practices, Improper waste management, unlabeled biohazard materials	Infection control nurse, Assigned staff, Head Nurse, Nursing supervisor and other staff who notices.
7.	Equipment failure when needed for patient care	Failure of equipment, missing parts. Overdue of calibration, shock or bum. spark	Assigned staff, Head Nurse, Nursing supervisor and other staff who notices.
8.	Blood Transfusion Reactions	Due to transfusion of blood	Assigned staff, Head Nurse, Nursing supervisor, Blood bank staff and doctors
9.	Adverse Drug reaction	Any adverse drug reaction due to the medicine administered	Assigned staff, Head Nurse, Nursing supervisor, Clinical pharmacist and Doctors.
10.	Food Drug interactions	Any potential effect of food and drug intake	Clinical pharmacist. dietician, Nurse
11.	Documentation errors	Medical record documentation of errors	Assigned staff, Head Nurse, Nursing supervisor, MRD staff

Facility Safety			
1.	Fungal growths	Wall, ceiling, pipes etc.	Infection control nurse, Assigned staff, Head Nurse, Nursing supervisor and other staff who notices.
2.	Structural defects	Leakage, broken tile, sharp edges, rusted surfaces, slippery surfaces	Infection control nurse, Assigned staff, Head Nurse, Nursing supervisor and other staff who notices.
3.	Pediatric/vulnerable patients bed's without rails	Un raised side rails or defective side rails, no provision for side rails, etc.	Infection control nurse, Assigned staff, Head Nurse, Nursing supervisor and other staff who notices.
4.	Electrical safety	Short circuits, sparks, shocks, dislodged fittings	Infection control nurse, Assigned staff, Head Nurse, Nursing supervisor and other staff who notices.
5.	Fire safety	Fire exit blocked, in adequate fire safety measures, no functioning of safety measures like fire sprinkler, smoke detector, fire alarm, fire extinguishers etc.	Security, Nurse, Admin Staff
6.	Radiation safety	Over exposure, inadequate PPES, MRI related events or injury, violation of rules	Nurse, Technician

Staff safety			
1.	Needle/sharp Prick Injury	All sharp injury (break of skin with any sharp instrument such as hypodermic needle previously used on a patient)	Staff, Infection control nurse
2.	Blood and body fluid exposure	Mucosal exposure (blood or body fluids coming into contact with eyes, mouth etc.)	Staff, Infection control nurse, lab staff
3.	Fall	Within the hospital premises	Staff or supervisor
4.	Burns	Chemical or electrical burns	Staff or supervisor
5.	Inappropriate PPE	Poor compliance to infection control protocols, lack of PPEs	Staff or supervisor
6.	Other injuries occurred within the hospital Setting	Burns Cut injury-due to fan, structural defect collision	Staff or supervisor
Others			
1.	Code	Physical Assault, security threat	Any staff
2.	External & Internal disasters	**External**: Natural calamities affecting the hospital Mass casualty etc, **Internal**: Structural breakdown, explosion of gas cylinders, spread of infectious disease, leakage of hazardous gas etc	Any staff
3.	Fire	Outbreak of fire, sparks in the hospital premises	Any staff

4.	Infected/Hazmat material Spillage	Blood, Body fluid, contaminated fluid, Mercury, Leakage of gas, Hazardous chemicals	Any staff
5.	Thefts	Within the hospital premises	Any staff
6.	Violation of patient Rights	Patient or families felt that their rights are not protected and reported the same.	Any staff, Complaints received from patients relatives, patient welfare staff
7.	Violation of employee Rights	Hospital violated any of the employee rights	Any staff
8.	Patient absconding	After receiving patient in the ward	Head Nurse/ Nursing supervisor

9.	**An unexpected incident, related to system or process deficiencies, which leads to death or major and enduring loss of function for a recipient of health care services.** (Refer sentinel events- page 5)	These include, 1. Any patient death, coma or major disability, which can be attributed to medication error. 2. Suicide within hospital and within 72 hrs. of discharge from ICU 3. Absconding from a high intensity care setting 4. Abduction of patient 5. Child abduction and delivery of baby into wrong people. 6. Intra partum maternal death 7. Assault, murder rape, child abuse and other reportable injuries 8. Patient fall resulting in serious injury. 9. Hemolytic transfusion reactions.	Any staff

		10. Operating on wrong patient, wrong site side. 11. Left behind foreign body in the patient such as sponge etc	
10.	Documentation error	Wrong/missed documentation leads to error	Billing, front office, medical record
11.	Accident	Any uneventful occurrence in the hospital	Any staff

CONTROLLED DOCUMENT

List of SRES (Serious Reportable Events) or Sentinel Events

1. SURGICAL OR INVASIVE PROCEDURE EVENTS

d. Surgery or other invasive procedure performed on the wrong site

e. Surgery or other invasive procedure performed on the wrong patient

f. Wrong surgical or other invasive procedure performed on a patient

g. Unintended retention of a foreign object in a patient after surgery or other invasive procedure

h. Intra operative or immediately postoperative/post procedure death in an ASA Class 1 patient

2. PRODUCT OR DEVICE EVENTS

a. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting.

b. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.

c. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting

3. RADIOLOGIC EVENTS

Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area

4. PATIENT PROTECTION EVENTS

a. Discharge or release of a patient/resident of any age, who is unable to make decisions. to other than an authorized person.

b. Patient death or serious injury associated with patient elopement (disappearance) Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting

5. POTENTIAL CRIMINAL EVENTS

a. Any instance of care ordered by or provided by someone impersonating a physician. nurse, pharmacist, or other licensed healthcare provider.

b. Abduction of a patient/resident of any age

c. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting. Death or serious injury of a patient or staff member resulting from a physical assault (ie, battery) that occurs within or on the grounds of a healthcare setting

6. ENVIRONMENTAL EVENTS

a. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting

b. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances

c. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting

d. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting

7. CARE MANAGEMENT EVENTS

a) Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate. wrong preparation, or wrong route of administration).

b) Patient death or serious injury associated with unsafe administration of blood products

c) Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting.

d) Death or serious injury of a neonate associated with labor or delivery in a low risk pregnancy

e) Patient death or serious injury associated with a fall while being cared for in a healthcare setting.

f) Any Stage 3 Stage 4, and un stage able pressure ulcers acquired after admission/presentation to a healthcare setting

g) Artificial insemination with the wrong donor sperm or wrong egg.

h) Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen

i) Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.