EVENTS FOR SERIOUS SAFETY EVENT (SSE) REVIEW

TGH Risk Department contact name: * . Email: * . Phone #: .

SERIOUS SAFETY EVENT WORKSHEET

Event Date:		MRN:
Event Report Date:	Event Number:	Name:

SERIOUS SAFETY EVENT CATEGORY

SURGICAL/INVASIVE PROCEDURE EVENTS

- ☐ Surgery or other invasive procedure performed on the wrong site *†
- ☐ Surgery or other invasive procedure performed on wrong patient*†
- ☐ Wrong surgical or other invasive procedure performed on a patient
- ☐ Unintended retention of a foreign object in a patient after surgery or other invasive procedure *†
- ☐ The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition
- ☐ The surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage is not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process
- ☐ Intraoperative or immediately postoperative/post-procedure death in an ASA Class 1 patient

POTENTIAL CRIMINAL EVENTS

- ☐ Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
- ☐ Abduction of a patient/resident of any age
- ☐ 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 (i.e., battery) that occurs within or on the grounds of a healthcare setting

PRODUCT OR DEVICE EVENTS

- ☐ Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
- ☐ 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
- ☐ Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting

RADIOLOGIC EVENTS

- ☐ Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area
- ☐ Prolonged fluoroscopy with cumulative dose >1500 rads to a single field, or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose†

ENVIRONMENTAL EVENTS

- ☐ Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
- ☐ 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
- ☐ 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
- ☐ Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting

PATIENT PROTECTION EVENTS

- ☐ Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person*†
- ☐ 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, or within 72 hours of discharge*†

CARE MANAGEMENT EVENTS

- ☐ 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)
- ☐ Patient death or serious injury associated with unsafe administration of blood products
- ☐ Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
- ☐ Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
- ☐ Patient death or serious injury associated with a fall while being cared for in a healthcare setting
- ☐ Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
- ☐ Artificial insemination with the wrong donor sperm or wrong egg
- ☐ Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
  Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results
- ☐ Severe neonatal hyperbilirubinemia (bilirubin >30 mg/dL) †
- ☐ Death of a patient as a result of an adverse event
- ☐ Brain or spinal damage to a patient as a result of an adverse event

ROOT CAUSE DETERMINATION:

After analysis, was this event considered preventable? ☐ Yes ☐ No

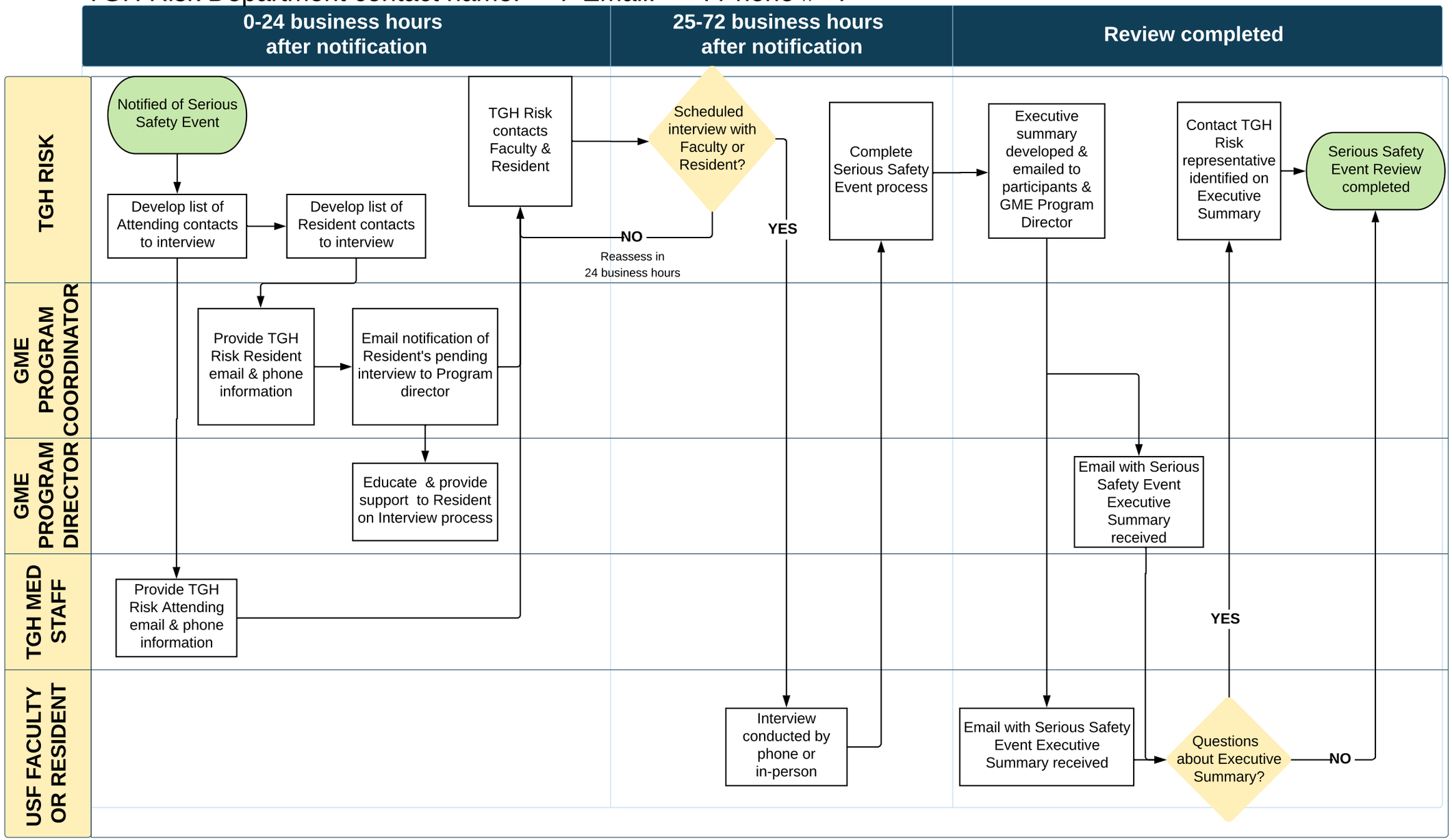
Disclosure and follow-up to the family? ☐ Yes ☐ No

†Joint Commission Sentinel Event; *†Sentinel Event and NQF Never Event; AHCA Code 15 in red

PROCESS FOR SERIOUS SAFETY EVENTS AT TGH

v2. 1/2019

TGH Risk Department contact name: * . Email: * . Phone # .



INFORMATION FOR SERIOUS SAFETY EVENT (SSE) INTERVIEW

TGH Risk Department contact name: * . Email: * . Phone #: .

EVENT TIMELINE

Date & Time	**Source** (Med Record, interview, etc.)	**Event** (Description & Response) What happened?	**Deviation from Expected Practice** (if applicable) What normally happens? What do policies/procedures require?	**What usually happens?** How often does this type of deviation occur (rare, common, very frequently)?

- TGH's Risk Department will contact any USF Faculty and Residents who were present during the Serious Safety Event.

- TGH's Risk Department will email and/or phone to schedule Serious Safety Event Review interviews (phone or in-person) that will last approximately 10-15 minutes. USF GME and TGH expect Faculty and Residents to respond to TGH's Risk Department within 48 business hours unless on official leave.

- Open-ended questions will be asked to complete the Event Timeline.

- Any USF Faculty and Residents interviewed will be emailed an Executive Summary of the Serious Safety Event once an action plan has been developed. Any questions regarding this Executive Summary can be directed to TGH's Risk Department (Contact: *, Phone #*). The Resident's Program Director should be cc'd on any email sent to Residents.