وزارة الصحة
Ministry of Health

Saudi Patient
Safety Taxonomy

Table of Contents

01	Ministry of Health Message	01
02	Introduction and Executive Summary	03
03	Saudi Patient Safety Taxonomy (S-PST)	07
3.1	Introduction	08
3.2	Frequent Asked Questions	08
3.3	Future Plans for Saudi Patient Safety Taxonomy	11
3.4	Taxonomy update mechanism	11
3.5	Automation of Saudi Patient Safety Taxonomy (S-PST)	13
3.6	Taxonomy Implementation Plan	14
04	Research Resources and Methods	15
4.1	Research Taskforce	16
4.2	Research Approach and Process	16
4.3	Research Principles	17
4.4	Workshops Photos	18
05	Patient Safety Terminologies and Definition	19
06	Structure of Patient Safety Taxonomy	36
07	Contents of Saudi Patient Safety Taxonomy	39
7.1	Domain Level	40
7.2	Impact Level	40
7.3	Category Level	41
7.4	Categories, Subcategories and Details	42
08	Acknowledgements	81
09	Appendix - References	83

01

Ministry of Health Message

Patient Safety is considered as a top priority for the healthcare services provided by the ministry of health in Saudi, which has been evident in the quality improvement carried projects and initiatives carried out through MOH facilities. And to ensure the safety of services provided is measurable and can be continuously improved. We made the commitment to unify the key concepts of patient safety and categories of patient safety events. Such standardization will help healthcare facilities at MOH and different healthcare sectors to measure, compare and improve patient safety. We aim that using the Saudi patient safety taxonomy will support the transparency, the spread of patient safety culture and encourage research in the field. We would like to thank all the contributing sectors to the development of the Saudi Patient Safety Taxonomy and we are looking forward for its spread and usage among all the healthcare facilities from the different sectors in Saudi to get the best benefit of it.

02

Introduction and Executive Summary

A key progress in the patient safety movement has been the call for a common language - **a taxonomy** -for categorizing medical events. The concept of a taxonomy combines terminology and the science of classification - in the case of patient safety, the Identification and classification of things that go wrong in health care, the causes why they occur, and the preventive approaches that can minimize their reoccurrence.

In this regard, multiple efforts and initiatives were established different international organizations, to standardize the language of science of patient safety, which will help researchers, patient safety and quality professionals to study the common issues and extract information that can help in studying patient safety issues, conduct benchmark measurements and recommend effective solutions. Starting with the constructed taxonomy by the Joint commission in (2005), an updated taxonomy was released by the World Health Organization in (2009).

In the kingdom of Saudi Arabia multiple healthcare sectors (governmental, private, military, university hospitals and medical cities) exists, and there is a variable classification systems of patient safety data adopted among those sectors and their related organizations. Such existing inconsistency, limits the ability for efficient patient safety data aggregation, benchmarks, and research. Therefore, a collaborative efforts national efforts between expertise from different healthcare sectors representatives led by the MOH and in collaboration with health matrix a Saudi patient safety taxonomy was developed.

It is important to note that this classification is a conceptual framework for a national classification which aims to provide a reasonable understanding of patient safety to which existing regional and national classifications can relate.

In addition, it is worth mentioning that this national classification is in line with Saudi Arabia's 2030 Vision in health sector in the kingdom, and it is in line with the National Transformation Program 2020 objectives for the health sector in the Kingdom.

The **conceptual framework has been developed,** consisting of the following **high levels**

01 **Domain**

02 **Impact**

03 **Category**

04 **Subcategory**

05 **Details**

06 **Level of harm**

This framework represents the start of an on-going process of progressively **improving a common national understanding of terms and concepts relevant to patient safety.**

In addition, this document provides background information about the taxonomy structure and contents, as well as, the methodology of creating the conceptual framework. In addition, this document includes the common terminologies related to patient safety with their definitions.

National
Transformation
Program 2020

VISION رؤيـــة
2030
المملكة العربية السعودية
KINGDOM OF SAUDI ARABIA

المركز السعودي
لسلامة المرضى
SAUDI PATIENT
SAFETY CENTER

03

3.1 Introduction

Patient safety taxonomy has been on the national health agenda in the Kingdom of Saudi Arabia in the last few years. In Nov 2015, **King Faisal Specialist Hospital and Research Center (KFSH&RC)** organized a closed panel discussion session in Jeddah titled "*Towards a National Patient Safety Taxonomy*" panel members from different healthcare sectors participated in assessment and ideas generation. Initiatives continued and a workshop titled "*Improving MOH incident reporting system workshop*" initiated by the Ministry of Health quality improvement department with the collaboration of health matrix held on the 19th of Oct, 2016 in Riyadh to discuss the implications for improvement of MOH hospitals incident reporting system and to come up with recommendations and improvement plan.

Key representative of quality and patient safety from the Ministry of health, and different healthcare sectors have participated in the workshop. A key recommendation of the workshop was to develop and adopt a patient safety taxonomy system, and to take this initiative beyond MOH towards the national level. Hence, a multiple expertise taskforce from different health care sectors has been formed to develop patient safety taxonomy for the Saudi healthcare system.

3.2 Frequent Asked Questions

3.2.1 What is Saudi Patient Safety Taxonomy?

A classification comprises a set of concepts linked by semantic relationships. It provides a structure for organizing information to be used for many purposes, including national statistics, descriptive studies and evaluative research.

It is important to distinguish a classification from a reporting system that provides an interface to enable users to collect, store and retrieve data in a reliable and organized fashion.

3.2.2 What does Saudi Patient Safety Taxonomy include?

A patient Safety Taxonomy could include, but is not limited to, the following

01

Nomenclature and definition of terms and concepts related to patient safety.

02

Comprehensive Classification Structure and Algorithms that share characteristics and relationships among the different patient safety concepts and domains.

03

Coding that include symbols and numbers for ease of data collection and abstraction utilizing information technology.

3.2.3 Why Saudi Patient Safety Taxonomy?

The purpose of the national classification for Patient Safety is **to enable categorization of patient safety information using standardized sets of concepts with agreed definitions, preferred terms and the relationships between them.** The classification is designed to be a genuine conjunction of national perceptions of the main issues related to patient safety and to facilitate the description, comparison, measurement, monitoring, analysis and interpretation of information to improve patient care and its related policies.

The objectives of creating a national patient safety taxonomy are

- Facilitates the development of reliable organization- based, regional and national event reporting systems.
- Facilitates setting up priorities for and patient safety and quality improvement initiatives.

- Facilitates research projects and comparison of safety research findings.
- Enhances the internal and external comparison of safety data analysis and benchmarking within and across healthcare organizations.
- Allows for interoperability of computer data systems that collect information about these incidents for analysis, public reporting and policy making.
- Allows for components of the taxonomy to drive additional investigative processes.
- Facilitates the implementation of the best practice in terms of clinical and non-clinical classification based on various experiences in the region.

3.2.4 How to use the Taxonomy with paper based reporting system?

Saudi Taxonomy provides the **clinical and non-clinical incident hierarchy** (Categories, Sub-Categories) based on the incident nature and how it fits into the common practice in healthcare organizations, regardless of how it is labelled and described internally in your organization.

However, it is recommended to build the paper based form to be aligned with this Saudi taxonomy, and this will facilitate the process in the future when moving to electronic system.

3.2.5 How to use the Taxonomy when adopting an electronic system?

By adopting an electronic system in your organization, it would be easy to upload the taxonomy hierarchy into your system data base by building the same levels and structure in the system. That could be done easily by extracting the structure of the taxonomy into an excel sheet (through the website of taxonomy stated in this book) for uploading into the electronic system.

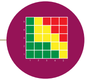
This will improve the user experience of **reporting** using a well-known taxonomy structure. This means you do not have to spend time and effort devising your own classification system and you can start capturing incident reports straight away.

3.3 Future Plans for Saudi Patient Safety Taxonomy

This Saudi- National Patient Safety Taxonomy is considered as **version 1**, while the task force is planning to release updated versions in the future, the **upcoming version will be extended to cover the following aspects**

Patient complaints Taxonomy

Mortality and Morbidity Taxonomy



Risk Management Framework

3.4 Taxonomy update mechanism

Taxonomy content is an important aspect where it should be maintained regularly, and the content would need to be reviewed in order to be aligned with the practices on the ground. Therefore, taskforce already considered the need of receiving the comments and feedback from all relevant parties in Healthcare sector, looking for improving the taxonomy content to ensure that the health sector is functioning optimally.

The taskforce has also developed the following mechanism **to receive and follow up feedback from healthcare facilities in the Kingdom**, and to include the **acceptable improvements** as appropriate:

- Feedback and comments related to the content of the Saudi Patient Safety Taxonomy will need to be sent to the Saudi Patient Safety Center as per the contact details mentioned at the end of this document.
- The representative of the Saudi Patient Safety Center collects all feedback and improvements and shares them with the taskforce.

- Taskforce meeting will be held quarterly in order to study and process all comments and feedback, this includes what has been accepted, and what has not along with the rejection reason(s).
- The representative of the Saudi Patient Safety Center will be working to create a comprehensive log for all accepted changes and any new amendments.
- The representative of the Saudi Patient Safety Center sends the decisions to all relevant parties who sent their feedback to ensure that the loop is closed properly.
- Publication and printing of the new version of the Saudi classification of patient safety on an annual base, including these approved changes and amendments

The task force members believe that the current version of the taxonomy covers the majority of aspects related to patient safety taxonomy. However, we strongly believe that such Taxonomy would need to be kept up-to-date, having said so the task force will have frequent quarterly meeting to discuss the potential improvement and enhancements which might need to be implemented on the taxonomy. During these frequent meetings the task force will discuss and approve any changes on the taxonomy based on the feedback. Healthcare organizations are encouraged to send their feedback to the following email address: info@spsc.gov.sa.

3.5 Automation of Saudi Patient Safety Taxonomy (S-PST)

As a part of developing the **S-PST communication channels** with all relevant teams in healthcare organizations, the taskforce decided to create **a closed LinkedIn group** in order to receive contributions and inputs from whoever is concerned with patient safety taxonomy. In addition, this group will be considered as a **voting channel** on the changes, improvements and any requests raised by any team member in this group.

On another hand, and for the same purpose of promoting the contribution to this national project, the taskforce will make this **S-PST document available as an electronic copy**, where users and concerned people can extract the contents into a different formats like excel sheets. This is part of achieving one of the technology objectives for healthcare sector in **National Transformation Program 2020.**

In collaboration with Health Matrix, the task force developed an **on-line portal software** to maintain the taxonomy. Health care sectors will have an access to the portal where they can download the taxonomy in different formats, and upload it to their local Incident reporting system. The software will be available on the Saudi Patient Safety Center website.

3.6 Taxonomy Implementation Plan

All healthcare sectors within Saudi Arabia as in the near future will be encouraged to report aggregated data related to Patient Safety and Incident Reporting using the taxonomy.

The following time table presents the Implementation plan

Milestone	Target completion date
Taxonomy **version 1.0** release	**2nd of December 2017**
Communicate the taxonomy to all healthcare sectors in Saudi Arabia	**5th of December 2017**
Orientation and Awareness session to all Healthcare sectors in Saudi Arabia	**14th of February 2018**
All Healthcare sectors to prepare their organizations to **start capturing incidents** using the Taxonomy coding	**14th of March 2018**

04

Research Resources and Methods

4.1 Research Taskforce

The taskforce was comprised of **experts** from the fields of patient safety, quality, health informatics, accreditation bodies, and medicine. From the start, the taskforce realized that the "problems do not lie with the words we use, but rather with the underlying concepts". This means that it is the conceptual definitions that are important, as well as the terms or labels assigned to the concepts. **Without universally accepted conceptual definitions, understanding will continue to be impeded.**

The taskforce members have long experience in their organizations, where their contribution was very helpful and necessary to **provide the credibility to this taxonomy** as they are part of national context in Saudi. However, the taskforce members will be listed in this book under the **"Acknowledgement Section"**

4.2 Research Approach and Process

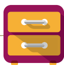
The project comprised a review and evaluate of an existing patient safety terminologies and taxonomies (classifications), and identification of those that should be included in the core set of a standardized taxonomy, assessment of the taxonomy's face and content validity, gathering of inputs from leaders of patient safety in multiple disciplines, voting on the proposed selections and a **preliminary study of the taxonomy's comparative reliability.**

Review White Papers

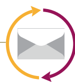
Assessment

Identify Core Set

Evaluate PS Existing Taxonomy



Gather Inputs from Taskforce



Voting Process

Final Outcome

The taskforce developed the conceptual framework over the course of 12 Months, there has been a strong commitment to ensuring the conceptual framework is a genuine convergence of national perceptions of the main issues related to patient safety. The **validity** of the conceptual framework for the national taxonomy was evaluated through a two-round voting and an in-depth review and analysis by experts representing the different fields mentioned earlier.

The conceptual framework **evaluated the country culture as well,** ensured that this national taxonomy fits for purpose, meaningful, useful and appropriate for classifying patient safety data and information.

4.3 Research Principles

In order to guide its' work in National Taxonomy, the taskforce followed a set of **principles**

- **The purpose** and potential users and uses for the classification be clearly articulated.
- **The classification** be based upon concepts as opposed to terms or labels.
- The language used for the **definitions** of the concepts be culturally and linguistically appropriate.
- The concepts be **organized** into meaningful and useful categories.
- The categories be **applicable** to the full spectrum of healthcare settings in Saudi, and GCC countries in the future.
- **The classification be complementary** to the WHO Family of International Classifications.
- **The conceptual framework** be a genuine convergence of national perceptions of the main issues related to patient safety.

4.4 Workshops Photos

05

Patient Safety **Terminologies** and **Definitions**

As part of the road map of building **S-PST**, standardization of terminologies and their definition is essential for this process. Therefore, this section has been designed to illustrate the proposed common language for patient safety taxonomy.

Predefined and agreed terminologies and definitions will help in facilitating the study of the taxonomy structure in much better way to move forward to addressing the taxonomy contents smoothly in the future.

Terminologies and Definitions

Incident

An event or circumstance that harmed or has the potential to harm a person or a property in relation to the organisation, resulting from human behaviour and/or system failure.

Patient Safety

Freedom from accidental or preventable injuries produced by medical care. Thus, practices or interventions that improve patient safety are those that reduce the occurrence of preventable adverse events.

Taxonomy

A standardized classification for key patient safety concepts. The purpose of the International Classification for Patient Safety is to enable categorization of patient safety information using standardized sets of concepts with agreed definitions, preferred terms, and the relationships between them based on explicit domain ontology It is designed to facilitate the description, comparison, measurement, monitoring, analysis and interpretation of information to improve patient care, and for epidemiological and health policy planning purposes.

Terminologies and Definitions

Moderate

Vital signs changes. Decreased level of consciousness. Additional medication/ treatment required. Invasive diagnostic procedure required.

Major

Any unexpected or unintended incident that caused permanent or long-term harm to one or more persons.

Sentinel Event

Is any event leading to serious patient harm or death and is caused by healthcare (human error/behaviour and/or system failure) rather than the patient's underlying illness.

Medication error

Is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer.

Adverse Drug Reaction

Response to a drug which is noxious and unintended which occurs at doses normally used in human for prophylaxis, diagnosis, or therapy of disease or for the modification of physiologic function.

Dispensing Phase/Stage

Errors that occur at any stage during the dispensing process from the receipt of a prescription in the pharmacy through to the supply of a dispensed product to the patient This is dispensing error.

High Alert Medication

Medications that bear a heightened risk of causing significant harm when used in error.

Administration Phase/Stage

The phase of giving of a pharmacologic or other therapeutic agent by the healthcare professionals. (stage)

Administration Error

Inappropriate procedure or improper technique in the administration of a drug. This is administration error.

Monitoring Phase/Stage

To observe or record relevant physiological or psychological signs during and after medication administration. (stage)

Monitoring Error

Failure to review a prescribed regimen for appropriateness and detection of problems, or failure to use appropriate clinical or laboratory data for adequate assessment of patient response to prescribed therapy. (error)

Preparation Error

Drug product incorrectly formulated or manipulated before administration. This is Preparation error.

Preparation Phase/Stage

Act or process of making the medication ready for administration. Pharmaceutical formulation is the process in which different chemicals/ substances are combined to produce a final medicinal product. Formulation is often used in any way that includes dosage form. (stage)

Prescribing Error

Incorrect drug selection (based on indications, contraindications, known allergies, existing drug therapy, and other factors), dose, dosage form, quantity, route, concentration, rate of administration, or instructions for use of a drug product ordered or authorized by physician (or other legitimate prescriber). This is a prescribing error.

Storage Phase/Stage

Process of keeping medications in a specially designed secure area or space of a building to avoid contamination or deterioration, avoid disfiguration of labels, maintain integrity of packaging and guarantee quality and potency of drugs during shelf life; prevent or reduce pilferage, theft to loss; and prevent infestation of pests and vermin.

Storage Error

Incorrect storage of a drug by the pharmacist, nurse or patient, altering the drug's potency. This is storage error.

Risk

Risk is the effect of uncertainty on objectives. Risk is often expressed in terms of a combination of the consequences of an event (including changes in circumstances) and the associated likelihood of occurrence.

Risk Assessment

Is the process where you identify hazards, analyse or evaluate the risk associated with that hazard, and determine appropriate ways to eliminate or control the hazard.

Risk Management

The process of identification, assessment, analysis and management of all risks and incidents for every level of the organization, and aggregating the results at a corporate level, which facilitates priority-setting and improved decision making to reach optimal balance of risk, benefit and cost.

Risk Analysis

Process used to determine the potential severity of the loss from an identified risk, the probability a loss will happen, and alternatives for dealing with the risk. Also, referred to as Hazard Analysis.

Risk Identification

Process that involves finding, recognizing and describing the risks that could affect the achievement of an organization’s objectives. It also includes identification of possible causes and potential consequences.

Likelihood

How likely (frequency) is it that the risk event will occur / reoccur.

Outcomes

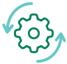
Is the quantified estimate of degree of harmor damage.

Risk Attitude

Organization's approach to assess and eventually pursue, retain, take or turn away from risk

Risk Source

Element which alone or in combination has the intrinsic potential to give rise to risk.



Risk Owner

Person or entity with the accountability and authority to manage a risk.

Risk Management Policy

Statement of the overall intentions and direction of an organization related to risk management.

Level of Risk

Magnitude of a risk or combination of risks, expressed in terms of the combination of consequences and their likelihood.

Terminologies and Definitions

Human Factors

The study of the interrelationships between humans, the tools they use, the environment in which they live and work, and the design of efficient, human cantered processes to improve reliability and safety.

Root Cause Analysis

Is an approach for identifying the underlying causes of an incident so that the most effective solutions can be identified and implemented? A Root Cause Analysis focuses primarily on systems/processes, and human factors.

Culture

Is the product of individual and groups values, attitudes, perceptions, competencies and patterns of behaviour that determine the commitment to, and the style and proficiency of, an organization's health and safety management

Environment

The circumstances, objects, or conditions surrounding an individual.

Mandatory Reporting

Refers to the legal requirement to report to authorities, which may apply to the general public, health practitioners and other professions.

Outcome

A final result, conclusion or impact after delivering the healthcare services.

Process

A series of related actions to achieve a defined outcome.

Surgical Site Infection

A surgical site infection is an infection that occurs after surgery in the part of the body where the surgery took place.

Just Culture

A process for achieving a balanced system and individual accountability in a manner that best supports patients, staff and the organizational values and objectives.

Human Error

Inadvertently doing other than what was intended: Skill based errors: a slip in action, lapse in memory, or mistakes: rule based errors or knowledge based errors.

At-risk behaviour

At-risk behaviour is a behavioural choice that increases risk where risk is not recognized or is mistakenly believed to be justified

Reckless Behaviour

Is a behavioural choice to consciously disregard a substantial and unjustifiable risk. It is an intentional risk taking; knowing risk associated with action but consciously disregards it.

Quality Management

It is the act of overseeing all activities and tasks needed to maintain a desired level of excellence. This includes the determination of a quality policy, creating and implementing quality planning and assurance, quality control and quality improvement.

Quality

Degree to which a set of inherent characteristics of an object fulfils requirements.

Terminologies and Definitions

Potential Error

Circumstances or events that have the capacity (potentiality) to cause error.

Voluntary Reporting

It is the process of reporting safety events, by anyone, being directly or indirectly involved, in a confidential manner.

Contributing Factor

Contributory Factors are those which affect the performance of individuals whose actions may have an effect on the delivery of safe and effective service or products.

Benchmark

Is the comparison of an organizations or practitioners results against a reference point (Best Practice) which enable organizations or individuals to set a target.

Work related Injury

It is an injury or illness caused, contributed or significantly aggravated by events or exposures in the work environment.

System Failure

A fault, breakdown or dysfunction within an organization's operational methods, processes or infrastructure.

Key Performance Indicators (KPIs)

Tool for measurement of a specific part of process & the achievement of a desired level of results in an area relevant to the evaluated entity’s activity.

Disclosure

Is to inform the patient, or the patient's representative, of any adverse event or error in his treatment.

Handoffs and Handover

The process when one health care professional updates another on the status of one or more patients for the purpose of taking over their care.

Safety Culture

The safety culture of an organization is the product of individual and group values, attitudes, perceptions competencies, and patterns of behaviour that determine the commitment to, and the style and proficiency of, an organization's health and safety management.

Time-out

Planned periods of quiet and/or interdisciplinary discussion focused on ensuring that key procedural details have been addressed. For instance, protocols for ensuring correct site surgery often recommend a time out to confirm the identification of the patient, the surgical procedure, site, and other key aspects, often stating them aloud for double-checking by other team members.

Best Practices

Best practices Clinical, scientific or professional practices that are recognized by a majority of professionals in a particular field. These practices are typically evidence based and consensus-driven.

Common Cause Variation

Variation in a process that is due to the process itself and is produced by interactions of variables of that process. Common-cause variation is inherent in all processes; it is not a disturbance in the process. It can be removed only by making basic changes in the process.

Mitigation

An action or circumstance which prevents or moderates the progression of an incident towards harming a patient.

Terminologies and Definitions

Hazard

An object or material that has the potential to cause harm.

Adverse Event

An event that results in unintended harm to the patient by an act of commission or omission rather than by the underlying disease or condition of the patient.

Circumstance

A situation or factor that may influence an event, agent or person(s).

Extravasation

Extravasation is when a chemotherapy medication or other drug leaks outside the vein onto or into the skin, causing a reaction.

Pressure Ulcer (Injury)

A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.

Stage 1 Pressure Injury: Non-blanchable erythema of intact skin

Colour changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis

Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

Stage 3 Pressure Injury: Full-thickness skin loss

Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Stage 4 Pressure Injury: Full-thickness skin and tissue loss

Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Near Fall

An event in which a person feels a fall is imminent but avoids it by compensatory action, such as grabbing a nearby object or controlling the fall.

Assisted Fall

Assisted Fall occurs when the patient begins to fall, is assisted by another person, but nevertheless reaches the ground or other unintended surface.

Terminologies and Definitions

Hazmat

A hazardous material is any item or agent (biological, chemical, radiological, and/or physical), which has the potential to cause harm to humans, animals, or the environment, either by itself or through interaction with other factors.

Extravasation Grade 1

Pain at infusion site, No swelling.

Extravasation Grade 2

Pain at infusion site, Swelling and No skin blanching.

Extravasation Grade 3

Pain at infusion site, Swelling, Skin blanching and Capillary refill normal.

Extravasation Grade 4

Pain at infusion site, Swelling, Skin blanching, Reduced, capillary refill, '+/- Decreased or absent distal pulse and '+/- Blistering or skin breakdown.

06

Saudi Patient **Safety Taxonomy**

06 Structure of Patient Safety Taxonomy

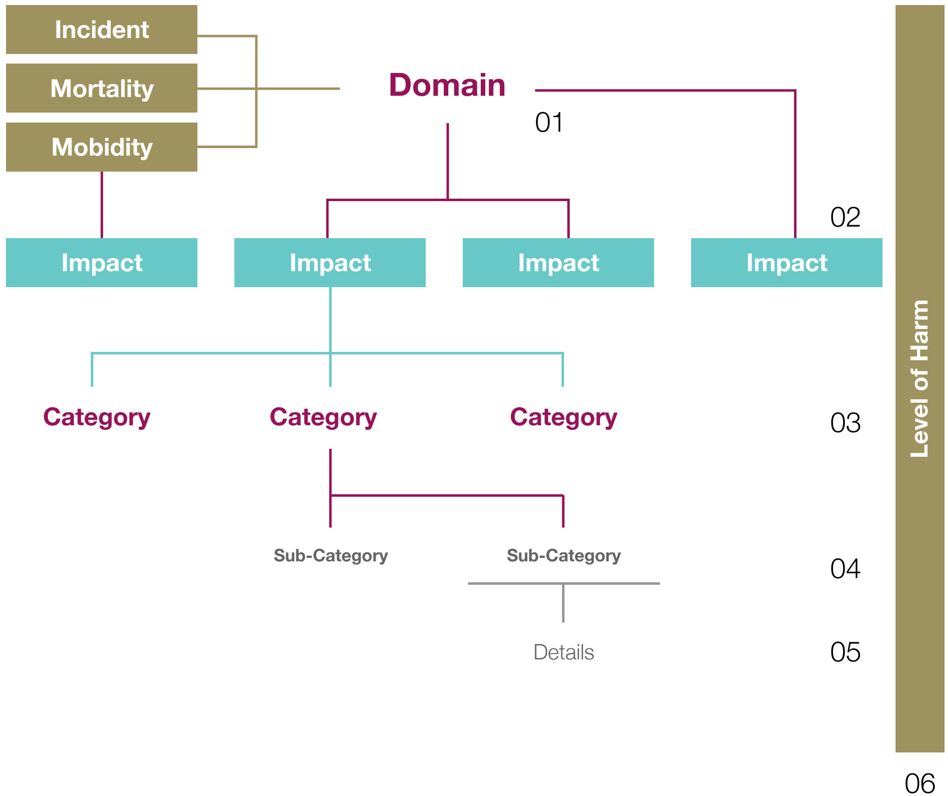
The taskforce designed the conceptual framework for the Structure of National Patient Safety Taxonomy to provide a much needed method of organizing patient safety data and information so that this data and information could be aggregated and analyzed.

The taxonomy **structure** consists of five different and interrelated levels in order to obtain information in a quick and easy manner. This structure is built based on hierarchical concept, so that there is a main level and sub-level to ensure that this taxonomy gives logical formula and scientific methodology in its build.

This section describes the 5 high level classes which comprise the conceptual framework for the national taxonomy for Patient Safety.

The conceptual framework aims to provide a comprehensive understanding of the domain of patient safety. It aims to represent a continuous learning and improvement cycle throughout and at any point within the conceptual framework.

In addition, the conceptual framework has identified a very significant level which is the "Level of Harm", and this is why it has been added as the **6th level** in the patient safety taxonomy.


Incident
Mortality
Mobidity
Domain
01
02
Impact
Impact
Impact
Impact
Category
Category
Category
03
Sub-Category
Sub-Category
04
Details
05
Level of Harm
06

Domain

The characteristics of the **setting in which an event** occurred it is also the type of **event criteria** and it isn't for type of individuals involved.

Impact

The influence, **outcomes** or effects of fields of groups that are affected by event result.

Category

The implied or visible **process** that were faulty or failed, these processes have a common nature, grouped because of **shared and agreed criteria.**

Sub-Category

The **factors** and agent **that led to an event**, describes the nature of the event or injury, and gives additional information.

Detail

Describes **further information** for nature of event in depth, and gives some information related to variances of event.

Level of Harm

The degree of injury, suffering, disability.

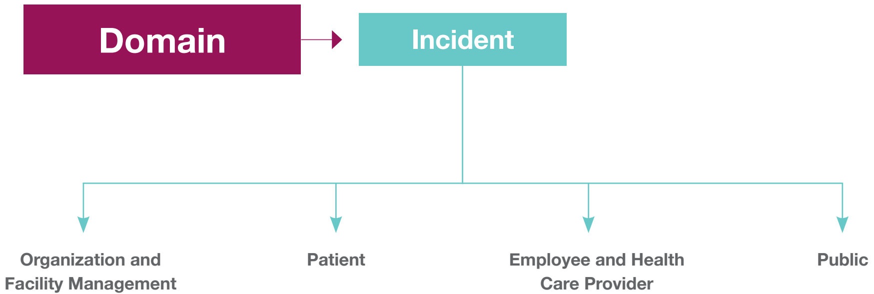
07

Saudi Patient

Safety Taxonomy

7.1 Domain Level

7.2 Impact Level



7.3 Categories

1. Security related issues.
2. Behavior.
3. Staff related issues.
4. Patient Care Management.
5. Laboratory related issues.
6. Procedural.
7. Medical Equipment Issues.
8. Facility Maintenance.
9. Environment /Safety.
10. Accommodation related issues.
11. Information technology related issues.
12. Medical imaging and diagnostic procedure.
13. Food Services.
14. Clinical Nutrition.
15. Infection Control related issues.
16. Occupational Health.
17. Housekeeping.
18. Intravenous.
19. Pressure Ulcer (Injury).
20. Skin Lesions / Integrity.
21. Medication.
22. Communication Issues.
23. Fall.
24. Radiation treatment (Ionizing radiation Non-Ionizing (Us, UV, Laser, Other).
25. Labor and delivery related issues.
26. Supply Chain issues (logistics).
27. Laundry services.
28. Sentinel Events.
29. ID/Document/Consent.

7.4 Categories and Subcategories and Details:

No.	Category		Subcategory		Details
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.1.	Potential/facility property damage
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.2.	Vandalism
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.3.	Physical Assault
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.4.	Actual or potential violent or out of control person
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.5.	Verbal Assault
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.6.	Inappropriate/Aggressive Behavior
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.7.	Left with permission and did not return
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.8.	Left with permission and returned late
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.9.	Left without permission and not returned -Absconded
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.10.	Left without permission and returned late
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.11.	Unauthorized entry
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.12.	Unauthorized usage of hospital property
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.13.	Fraud
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.14.	No property pass
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.15.	Smoking policy violation
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.16.	Unclaimed patient belongings
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.17.	Public Disorder

No.	Category	Subcategory			Details
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.18.	Room locked and can't be open
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.19.	Staff not wearing badges/ Identification while in hospital premises
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.20.	Poor security response
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.21.	No security staff in the building
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.22.	Noncompliance with visiting hours' policy
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.23.	Abusive, violent, disruptive or self-harming behavior
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.24.	Breach of confidentiality
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.25.	Door lock changed
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.26.	Suicidal Attempt
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.27.	Intended Self Harm
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.28.	Physical Harassment
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.29.	Verbal Harassment
1.	Security Related Issues	1.1.	General /Assault & Harassment	1.1.30.	Weapon Found
1.	Security Related Issues	1.2.	Suspected Abuse and Neglect by Healthcare provider/family	1.2.1.	Elderly Sexual
1.	Security Related Issues	1.2.	Suspected Abuse and Neglect by Healthcare provider/family	1.2.2.	Adult Sexual
1.	Security Related Issues	1.2.	Suspected Abuse and Neglect by Healthcare provider/family	1.2.3.	Child sexual

No.	Category	Subcategory			Details
1.	Security Related Issues	1.2.	Suspected Abuse and Neglect by Healthcare provider/family	1.2.4.	Elderly Neglect
1.	Security Related Issues	1.2.	Suspected Abuse and Neglect by Healthcare provider/family	1.2.5.	Child Neglect
1.	Security Related Issues	1.2.	Suspected Abuse and Neglect by Healthcare provider/family	1.2.6.	Adult Neglect
1.	Security Related Issues	1.3.	Theft and Lost	1.3.1.	Missing property
1.	Security Related Issues	1.4.	Narcotics and Dangerous Drugs	1.4.1	Controlled drug cabinet keys/ access issues
1.	Security Related Issues	1.4.	Narcotics and Dangerous Drugs	1.4.2.	Controlled medication count not done
1.	Security Related Issues	1.4.	Narcotics and Dangerous Drugs	1.4.3.	Controlled medication left unsecured
1.	Security Related Issues	1.4.	Narcotics and Dangerous Drugs	1.4.4.	Narcotic Broken Full ampoule/vial
1.	Security Related Issues	1.4.	Narcotics and Dangerous Drugs	1.4.5.	Controlled medication spilled
1.	Security Related Issues	1.4.	Narcotics and Dangerous Drugs	1.4.6.	Controlled medication-broken
1.	Security Related Issues	1.4.	Narcotics and Dangerous Drugs	1.4.7.	Controlled medication-inadvertent disposal
1.	Security Related Issues	1.4.	Narcotics and Dangerous Drugs	1.4.8.	Duplication Medication
2.	Behavior	2.1.	Noncompliant/ Uncooperative/ Inappropriate Behavior		
2.	Behavior	2.2.	Inconsiderate/ Rude/Hostile Behavior		
2.	Behavior	2.3.	Discrimination/ Prejudice Behavior		

No.	Category	Subcategory		Details
2.	Behavior	2.4.	Death Threat Behavior	
2.	Behavior	2.5.	Aggression Behavior	
2.	Behavior	2.6.	Disruptive behaviors	
2.	Behavior	2.7.	Family/sitter interfering with patient care	
3.	Staff related issues	3.1.	Refusal to perform assigned tasks	
3.	Staff related issues	3.2.	Non-Performance of Duty/Breach of Duty	
3.	Staff related issues	3.3.	Reporting for Retaliation	
3.	Staff related issues	3.4.	Bullying	
3.	Staff related issues	3.5.	Dress Code Violation	
3.	Staff related issues	3.6.	Inappropriate/ Irresponsible Behavior	
3.	Staff related issues	3.7.	Lack Professional Development	
3.	Staff related issues	3.8.	Staff Confidentiality/ Disclosure	
3.	Staff related issues	3.9.	Unfair Dismissal	
3.	Staff related issues	3.10.	Unfair workload	
3.	Staff related issues	3.11.	Wrongful Accusation	
3.	Staff related issues	3.12.	Physician not privileged	
3.	Staff related issues	3.13.	Non-compliance with organization policy and procedure	

No.	Category	Subcategory			Details
3.	Staff related issues	3.14.	Ethical issues		
4.	Patient care management	4.1.	Patient Disposition	4.1.1.	Delay in admitting patient
4.	Patient care management	4.1.	Patient Disposition	4.1.2.	Delay in discharging patient
4.	Patient care management	4.1.	Patient Disposition	4.1.3.	Delay in referral to home health care
4.	Patient care management	4.1.	Patient Disposition	4.1.4.	Delay in patient transfer
4.	Patient care management	4.1.	Patient Disposition	4.1.5.	Delay in transferring patient
4.	Patient care management	4.1.	Patient Disposition	4.1.6.	Delay of releasing deceased body
4.	Patient care management	4.1.	Patient Disposition	4.1.7.	Dispute regarding patient management
4.	Patient care management	4.1.	Patient Disposition	4.1.8.	Late Patient Arrival
4.	Patient care management	4.1.	Patient Disposition	4.1.9.	Unplanned / Unnecessary admission/ transfer
4.	Patient care management	4.1.	Patient Disposition	4.1.10.	Unplanned return to critical care (24hrs)
4.	Patient care management	4.1.	Patient Disposition	4.1.11.	Unplanned return to ED (72hrs)
4.	Patient care management	4.1.	Patient Disposition	4.1.12.	Improper/Unsafe transport of patient
4.	Patient care management	4.1.	Patient Disposition	4.1.13.	Appointment not entered
4.	Patient care management	4.1.	Patient Disposition	4.1.14.	Delayed for appointment time
4.	Patient care management	4.1.	Patient Disposition	4.1.15.	Improper patient discharge
4.	Patient care management	4.1.	Patient Disposition	4.1.16.	Wrong Appointment
4.	Patient care management	4.1.	Patient Disposition	4.1.17.	No/Incomplete admission orders
4.	Patient care management	4.1.	Patient Disposition	4.1.18.	Admission/Encounter-Ineligible patient

No.	Category	Subcategory		Details	
4.	Patient care management	4.1.	Patient Disposition	4.1.19.	Incorrect demographics
4.	Patient care management	4.1.	Patient Disposition	4.1.20.	Inappropriate restraint use
4.	Patient care management	4.1.	Patient Disposition	4.1.21.	Left Against Medical Advice (DAMA)
4.	Patient care management	4.1.	Patient Disposition	4.1.22.	No/Incomplete discharge orders
4.	Patient care management	4.1.	Patient Disposition	4.1.23.	No/Invalid consent obtained
4.	Patient care management	4.1.	Patient Disposition	4.1.24.	No/incomplete transfer orders
4.	Patient care management	4.1.	Patient Disposition	4.1.25.	No patient ID band
4.	Patient care management	4.1.	Patient Disposition	4.1.26.	No sitter to stay with patient
4.	Patient care management	4.1.	Patient Disposition	4.1.27.	Patient has more than one MRN
4.	Patient care management	4.1.	Patient Disposition	4.1.28.	Patient ID band/Wrong patient
4.	Patient care management	4.1.	Patient Disposition	4.1.29.	Chest tube clamped
4.	Patient care management	4.1.	Patient Disposition	4.1.30.	Missed diagnosis
4.	Patient care management	4.1.	Patient Disposition	4.1.31.	Critical results not acted upon
4.	Patient care management	4.1.	Patient Disposition	4.1.32.	No consultation when indicated
4.	Patient care management	4.1.	Patient Disposition	4.1.33.	Inadequate/incomplete assessment
4.	Patient care management	4.1.	Patient Disposition	4.1.34.	Refuse Male Physician
4.	Patient care management	4.1.	Patient Disposition	4.1.35.	Refuse Female Physician
4.	Patient care management	4.1.	Patient Disposition	4.1.36.	Refuse to Wait for XR Result
4.	Patient care management	4.1.	Patient Disposition	4.1.37.	Patient not prepared

No.	Category		Subcategory		Details
4.	Patient care management	4.1.	Patient Disposition	4.1.38.	Patient was not wearing the ID band
4.	Patient care management	4.1.	Patient Disposition	4.1.39.	Patient weight / height not updated
4.	Patient care management	4.1.	Patient Disposition	4.1.40.	Physician refused to attend
4.	Patient care management	4.1.	Patient Disposition	4.1.41.	Possible alternative interventions not utilized
4.	Patient care management	4.1.	Patient Disposition	4.1.42.	Treatment plan is not followed
4.	Patient care management	4.1.	Patient Disposition	4.1.43.	Unreleased tourniquet on patient's arm
4.	Patient care management	4.1.	Patient Disposition	4.1.44.	Inadequate treatment/intervention for condition
4.	Patient care management	4.1.	Patient Disposition	4.1.45.	Drowning/Near Drowning within hospital premises
4.	Patient care management	4.1.	Patient Disposition	4.1.46.	Delay in arrival of physician/ surgeon
4.	Patient care management	4.1.	Patient Disposition	4.1.47.	Inadequate pain management
4.	Patient care management	4.1.	Patient Disposition	4.1.48.	Procedure done without GA
4.	Patient care management	4.2.	Clinical Administration	4.2.1.	Wrong code announced
4.	Patient care management	4.2.	Clinical Administration	4.2.2.	No handover provided
4.	Patient care management	4.2.	Clinical Administration	4.2.3.	Handover-Inaccurate/incomplete information
5.	Laboratory related issues	5.1.	Delayed delivery of blood/blood products		
5.	Laboratory related issues	5.2.	Delayed feedback on rejected specimen		
5.	Laboratory related issues	5.3.	Incomplete blood/ blood products request		

No.	Category	Subcategory			Details
5.	Laboratory related issues	5.4.	Critical result not reported (Lab technician did not give results to physician)		
5.	Laboratory related issues	5.5.	Critical result reported but physician refused to accept results		
5.	Laboratory related issues	5.6.	Critical result not reported (Lab technician unable to contact physician)		
5.	Laboratory related issues	5.7.	Lost sample		
5.	Laboratory related issues	5.8.	Wrong Patient's MRN		
5.	Laboratory related issues	5.9.	Phlebotomy delayed		
5.	Laboratory related issues	5.10.	Transfusion reaction		
5.	Laboratory related issues	5.11.	Delayed Test Results		
5.	Laboratory related issues	5.12.	Delayed return of unused blood products		
5.	Laboratory related issues	5.13.	Unsuitable blood/ blood products		
5.	Laboratory related issues	5.14.	Wrong results		
5.	Laboratory related issues	5.15.	Unavailability of Blood and Blood products		
6.	Procedural	6.1.	Pre- Procedural	6.1.1.	Cancelation of Surgery
6.	Procedural	6.2.	During Procedural	6.2.1.	Emergency Case changed to Elective by Surgeon/Physician
6.	Procedural	6.2.	During Procedural	6.2.2.	Incomplete procedure on Surgery Schedule

No.	Category	Subcategory			Details
6.	Procedural	6.2.	During Procedural	6.2.3.	Incorrect Site/SIDE indicated on surgery schedule
6.	Procedural	6.2.	During Procedural	6.2.4.	Incorrect Medical Records
6.	Procedural	6.2.	During Procedural	6.2.5.	Incorrect PROCEDURE indicated on the surgery schedule
6.	Procedural	6.2.	During Procedural	6.2.6.	No Side indicated
7.	Medical Equipment issues	7.1.	Electrical items not tested	7.1.1.	
7.	Medical Equipment issues	7.2.	Home Care Equipment Issues		
7.	Medical Equipment issues	7.3.	Medical Equipment Broken or Abuse		
7.	Medical Equipment issues	7.4.	Medical equipment misuse		
7.	Medical Equipment issues	7.5.	Medical device unexpected failure		
7.	Medical Equipment issues	7.6.	Improper / missing tagging of medical equipment		
7.	Medical Equipment issues	7.7.	Medical equipment training related issues		
7.	Medical Equipment issues	7.8.	Delayed Response for New Medical Equipment Request.		
7.	Medical Equipment issues	7.9.	Delivered Device is not matching the Requirements.		
7.	Medical Equipment issues	7.10.	Poor biomedical engineering response to Emergency calls.		

No.	Category	Subcategory		Details
7.	Medical Equipment issues	7.11.	Medical Device PPM Over Due	
7.	Medical Equipment issues	7.12.	Medical Device violating safety standards	
8.	Facility Maintenance	8.1.	Heating, Ventilation, Air condition (HVAC) failure	
8.	Facility Maintenance	8.2.	Disruption of power supply	
8.	Facility Maintenance	8.3.	Failure of elevators	
8.	Facility Maintenance	8.4.	Medical items misuse	
8.	Facility Maintenance	8.5.	Misuse of Hospital property	
8.	Facility Maintenance	8.6.	Foul smell from bathroom drain	
8.	Facility Maintenance	8.7.	Foul smells from A/C systems	
8.	Facility Maintenance	8.8.	Generator Failure	
8.	Facility Maintenance	8.9.	Malfunction of Automated Doors	
8.	Facility Maintenance	8.10.	Medical gas leaks	
8.	Facility Maintenance	8.11.	Poor maintenance response	
8.	Facility Maintenance	8.12.	Overflow of Sewage	
8.	Facility Maintenance	8.13.	Disruption of water systems/ services/Flooding	
8.	Facility Maintenance	8.14.	Water leaks	
8.	Facility Maintenance	8.15.	Disruption of AC systems	
8.	Facility Maintenance	8.16.	issue in Chiller	

No.	Category	Subcategory		Details
8.	Facility Maintenance	8.17.	Delay in maintenance work	
8.	Facility Maintenance	8.18.	Major Disruption of power supply	
8.	Facility Maintenance	8.19.	Major Disruption of water systems/ services or Flooding	
8.	Facility Maintenance	8.20.	Steam Drop	
9.	Environmental/ Safety	9.1.	Fire	
9.	Environmental/ Safety	9.2.	Blocked access to emergency exit doors	
9.	Environmental/ Safety	9.3.	Blocked access to firefighting equipment	
9.	Environmental/ Safety	9.4.	Blocked corridors and hallways	
9.	Environmental/ Safety	9.5.	Defective fire sectoring doors	
9.	Environmental/ Safety	9.6.	Exposed electrical wiring	
9.	Environmental/ Safety	9.7.	No/poor response from dispatcher	
9.	Environmental/ Safety	9.8.	External projects safety violations	
9.	Environmental/ Safety	9.9.	Fire Alarm Related Issues	
9.	Environmental/ Safety	9.10.	Fire and Safety hazards	
9.	Environmental/ Safety	9.11.	Improper emergency exit sign (Missing or defective)	

No.	Category	Subcategory		Details
9.	Environmental/ Safety	9.12.	Improper condition of firefighting systems (e.g. Over-due inspection)	
9.	Environmental/ Safety	9.13.	Projects safety violations (Internal/External)	
9.	Environmental/ Safety	9.14.	Fire alarms not working	
9.	Environmental/ Safety	9.15.	Noise pollution	
9.	Environmental/ Safety	9.16.	Improper usage of personal protective equipment (PPE)	
9.	Environmental/ Safety	9.17.	Emergency call system malfunction	
9.	Environmental/ Safety	9.18.	Monitor Alarm Turned Off	
9.	Environmental/ Safety	9.19.	Safety precautions not followed	
9.	Environmental/ Safety	9.20.	Fire room blocked	
9.	Environmental/ Safety	9.21.	Heavy hanged equipment fall to the floor	
9.	Environmental/ Safety	9.22.	Lack of ramp for emergency evacuation	
9.	Environmental/ Safety	9.23.	Violating Smoking Policy	
9.	Environmental/ Safety	9.24.	Improper uses of fire hose reel	
9.	Environmental/ Safety	9.25.	Broken medical gas valve box	
9.	Environmental/ Safety	9.26.	Electrical cabinet\ room not locked	

No.	Category	Subcategory		Details
9.	Environmental/ Safety	9.27.	High pressure supply of Nitrous oxide	
9.	Environmental/ Safety	9.28.	Improper gas storage / not secured	
9.	Environmental/ Safety	9.29.	Improper handling of biohazard waste	
9.	Environmental/ Safety	9.30.	improper storage of chemicals	
9.	Environmental/ Safety	9.31.	No call bell inside the bathroom	
9.	Environmental/ Safety	9.32.	No fire alarm pull station	
9.	Environmental/ Safety	9.33.	No warning sign upon mapping the floor	
9.	Environmental/ Safety	9.34.	Oxygen cylinder regulator not connected properly	
9.	Environmental/ Safety	9.35.	Oxygen cylinders not replaced	
9.	Environmental/ Safety	9.36.	Sharp edge plate on main access door	
9.	Environmental/ Safety	9.37.	Smoke detector removed	
9.	Environmental/ Safety	9.38.	Unknown chemical, potentially hazardous	
10.	Accommodation related issues	10.1.	The Arrival of candidates to accommodation without Prior Notice form HR/ Recruitment	
10.	Accommodation related issues	10.2.	Delay of Housing Maintenance	

No.	Category		Subcategory	Details
10.	Accommodation related issues	10.3.	Furniture misuse	
10.	Accommodation related issues	10.4.	Lack of Cooking Facilities	
10.	Accommodation related issues	10.5.	Lack of Laundromat Facilities	
10.	Accommodation related issues	10.6.	Lack of Refrigerator Facilities	
10.	Accommodation related issues	10.7.	Housing security	
10.	Accommodation related issues	10.8.	Unauthorized design modification	
10.	Accommodation related issues	10.9.	Unsafe Environment	
11.	Information technology related issues	11.1.	Abuse of system authorities	
11.	Information technology related issues	11.2.	Accessing systems using someone else's authorization e.g. someone else's user id and password	
11.	Information technology related issues	11.3.	Disruption of Information Technology services	
11.	Information technology related issues	11.4.	Information security Issues	
11.	Information technology related issues	11.5.	Information leakage due to software errors	
11.	Information technology related issues	11.6.	Spreading of viruses	
11.	Information technology related issues	11.7.	Poor IT response.	

No.	Category	Subcategory		Details
11.	Information technology related issues	11.8.	Lack of IT Supplies (e.g. ink, PC, scanner, printers, DSL Modem, phone, pager)	
11.	Information technology related issues	11.9.	Posting or sharing official or patient information on social networking websites.	
11.	Information technology related issues	11.10.	Someone asking to reset passwords not belonging to them	
11.	Information technology related issues	11.11.	Security weakness within the system	
11.	Information technology related issues	11.12.	Inappropriate storage facilities for patient related information	
12.	Medical imaging and diagnostic procedure	12.1.	Delay of reporting Images for diagnosis	
12.	Medical imaging and diagnostic procedure	12.2.	Failure to comply with reporting of critical finding	
12.	Medical imaging and diagnostic procedure	12.3.	No NPO Order	
12.	Medical imaging and diagnostic procedure	12.4.	High Creatinine Level	
13.	Food services	13.1.	Cold meal delivered	
13.	Food services	13.2.	Delayed meal delivery	
13.	Food services	13.3.	Foreign object found in food	
13.	Food services	13.4.	Lack of information on meal request	

No.	Category	Subcategory		Details
13.	Food services	13.5.	Incorrect Storage of food	
13.	Food services	13.6.	Late meal modifications	
13.	Food services	13.7.	Problems related to ordering, prescription and serving of feed/ foods/fluids	
13.	Food services	12.8. V	Storage of expired food	
13.	Food services	13.9.	Wrong meal request	
13.	Food services	13.10.	Diet for Wrong Patient	
13.	Food services	13.11.	Wrong Diet	
13.	Food services	13.12.	Wrong Quantity	
13.	Food services	13.3.	Expired-food item/formula	
13.	Food services	13.14.	Food trays not distributed	
13.	Food services	13.15.	Food wastage	
13.	Food services	13.16.	Inappropriate Formula Labeling	
13.	Food services	13.17.	Patient NPO/ Food served	
14.	Clinical Nutrition	14.1.	Absence of diet Order by Physicians	
14.	Clinical Nutrition	14.2.	Absence/ Delay of diet recommendation by Clinical Dietitian	
14.	Clinical Nutrition	14.3.	Incorrect patient diet	

No.	Category	Subcategory		Details
14.	Clinical Nutrition	14.4	Absence/Delay of Nutritional Assessment of Clinical Dietitian	
14.	Clinical Nutrition	14.5.	Wrong Frequency by Clinical Dietitian	
14.	Clinical Nutrition	14.6.	Diet order not updated	
14.	Clinical Nutrition	14.7.	Known allergy	
14.	Clinical Nutrition	14.8.	Incorrect order	
14.	Clinical Nutrition	14.9.	Unknown allergy	
15.	Infection Control related issues	15.1.	Pest Control	
15.	Infection Control related issues	15.2.	Overfilling sharp containers	
15.	Infection Control related issues	15.3.	Protocols for Handling of Body Fluids/Tissues	
15.	Infection Control related issues	15.4.	Device, Product, Medication, Fluid Associated Infections	
15.	Infection Control related issues	15.5.	Hand-hygiene Processes/ Procedures	
15.	Infection Control related issues	15.6.	HazMat	
15.	Infection Control related issues	15.7.	Protocols for Immunocompromised Patients	
15.	Infection Control related issues	15.8.	Medical Waste	
15.	Infection Control related issues	15.9.	Improper Practice of Infection Control Recommendations	
15.	Infection Control related issues	15.10.	Protocols for Infected Patients	

No.	Category	Subcategory		Details
15.	Infection Control related issues	15.11.	Non-Availability of Biohazard Spill Kit	
15.	Infection Control related issues	15.12.	Safe Injection/ Sharps Disposal Processes/ Procedures	
15.	Infection Control related issues	15.13.	Exposure to infected persons/ areas	
15.	Infection Control related issues	15.14.	Intravascular Cannula	
15.	Infection Control related issues	15.15.	Infected Prosthesis/Site	
15.	Infection Control related issues	15.16.	Non-compliance with bundles	
15.	Infection Control related issues	15.17.	Collecting waste bags	
15.	Infection Control related issues	15.18.	Improper biohazard sharps disposal	
15.	Infection Control related issues	15.19.	Improper cleaning	
15.	Infection Control related issues	15.20.	Improper infected & contaminated laundry handling	
15.	Infection Control related issues	15.21.	Improper medical waste collection	
15.	Infection Control related issues	15.22.	Lack of pre-operative cleaning	
15.	Infection Control related issues	15.23.	Contamination Body	
15.	Infection Control related issues	15.24.	Improper Dressing	
15.	Infection Control related issues	15.25.	Lack of follow up on patient LABELLED FOR ISOLATION	
15.	Infection Control related issues	15.26.	Negative pressure not functioning	

No.	Category	Subcategory		Details
15.	Infection Control related issues	15.27.	Poor hand hygiene	
15.	Infection Control related issues	15.28.	Patient not placed in isolation room	
15.	Infection Control related issues	15.29.	Porta cath line infection	
15.	Infection Control related issues	15.30.	Positive result endotoxin from carbon filter	
15.	Infection Control related issues	15.31.	RO2 sample not collected for disinfection	
15.	Infection Control related issues	15.32.	Sharp container not available	
16.	Occupational health	16.1.	Manual handling	
16.	Occupational health	16.2.	Accidents caused by external projects	
16.	Occupational health	16.3.	Accidents caused by internal projects	
16.	Occupational health	16.4.	Contact with hazardous substance	
16.	Occupational health	16.5.	Accidental exposure to radiation	
16.	Occupational health	16.6.	Other sharps injury	
16.	Occupational health	16.7.	Electric shock	
16.	Occupational health	16.8.	Injury from facility damages (Falling tiles etc.)	
16.	Occupational health	16.9.	Lifting Equipment or Machinery	
16.	Occupational health	16.10.	Slips, trips and collisions	

No.	Category	Subcategory		Details
16.	Occupational health	16.11	Injury caused by physical or mental strain	
16.	Occupational health	16.12.	Traffic Accident (Outside the organization performing organizational duty)	
16.	Occupational health	16.13.	Injury caused by workplace violence or assaults	
17.	Housekeeping	17.1.	Cleanliness of facilities	
17.	Housekeeping	17.2.	Poor housekeeping response	
17.	Housekeeping	17.3.	Lack of housekeeping items supplies	
17.	Housekeeping	17.4.	Medical/non-medical waste mixing	
17.	Housekeeping	17.5.	Misuse of housekeepers	
18.	Intravenous	18.1.	Grade 1/ Extravasation	
18.	Intravenous	18.2.	Grade 2/ Extravasation	
18.	Intravenous	18.3.	Grade 3/ Extravasation	
18.	Intravenous	18.4.	Grade 4/ Extravasation	
18.	Intravenous	18.5.	Accidental Dislodgement	
18.	Intravenous	18.6.	Occlusion	
18.	Intravenous	18.7.	Infiltration	

No.	Category	Subcategory		Details
18.	Intravenous	18.8.	Wrong Label/ Instruction	
18.	Intravenous	18.9.	Accidental Removal/ Dislodge	
18.	Intravenous	18.10.	Phlebitis	
18.	Intravenous	18.11.	Remove / Changed without Order	
18.	Intravenous	18.12.	Not Sutured	
18.	Intravenous	18.13.	Wrong Connection	
18.	Intravenous	18.14.	Wrong insertion	
18.	Intravenous	18.15.	Long time to change	
18.	Intravenous	18.16.	Leaking	
19.	Pressure ulcer (injury)	19.1.	Stage 1	
19.	Pressure ulcer (injury)	19.2.	Stage 2	
19.	Pressure ulcer (injury)	19.3.	Stage 3	
19.	Pressure ulcer (injury)	19.4.	Stage 4	
19.	Pressure ulcer (injury)	19.5.	Deep Tissue Injury	
19.	Pressure ulcer (injury)	19.6.	Indeterminable/ Mucous Membranes	
19.	Pressure ulcer (injury)	19.7.	Indeterminable/ Under Non-Removal Dressing or Device	
19.	Pressure ulcer (injury)	19.8.	Suspected Deep Tissue Injury	
19.	Pressure ulcer (injury)	19.9.	Unstageable	
20.	Skin lesions/ Integrity	20.1.	Abrasion	

No.	Category	Subcategory		Details	
20.	Skin lesions/ Integrity	20.2.	Bruise\Skin Lesion		
20.	Skin lesions/ Integrity	20.3.	Cut Wound		
20.	Skin lesions/ Integrity	20.4.	Hematoma		
20.	Skin lesions/ Integrity	20.5.	Skin tear		
20.	Skin lesions/ Integrity	20.6.	Surgical wound site		
20.	Skin lesions/ Integrity	20.7.	Redness		
20.	Skin lesions/ Integrity	20.8.	Skin peeling		
20.	Skin lesions/ Integrity	20.9.	Cellulitis		
20.	Skin lesions/ Integrity	20.10.	Excoriation		
20.	Skin lesions/ Integrity	20.11.	Rash		
20.	Skin lesions/ Integrity	20.12.	Blister		
20.	Skin lesions/ Integrity	20.13.	Wound Dehiscence		
21.	Medication	21.1.	Adverse Drug Reaction	21.1.1.	Preventable Adverse Drug Reaction
21.	Medication	21.1.	Adverse Drug Reaction	21.1.2.	Non-Preventable Adverse Drug Reaction
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.1.	Wrong administration technique
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.2.	Patient allergic to treatment

No.	Category	Subcategory		Details	
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.3.	Charting error
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.4.	Communication problem
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.5.	Compliance error
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.6.	Contraindication
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.7.	Medication Delivery Delay
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.8.	Wrong/unclear dose

No.	Category	Subcategory		Details	
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.9.	Drug-drug interaction
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.10	.Drug passed expiry date
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.11.	Wrong dosage form
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.12.	Wrong frequency
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.13.	Wrong/omitted height
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.14.	High Alert Label Missing

No.	Category	Subcategory		Details	
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.15.	Wrong/omitted patient information leaflet
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.16.	Medication duplication
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.17.	Wrong patient
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.18.	Omitted medicine label
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.19.	Omitted medicine/ingredient
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.20.	Omitted/Wrong diagnosis

No.	Category	Subcategory			Details
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.21.	Wrong method of preparation
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.22.	Wrong quantity
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.23.	Adverse drug reaction (when used as intended)
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.24.	Wrong route
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.25.	Wrong storage
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.26.	Unauthorized prescriber

No.	Category	Subcategory		Details	
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.27.	Medication unavailable
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.28.	Wrong/omitted verbal patient directions
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.29.	Wrong/omitted weight
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.30.	Wrong/omitted expiry date
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.31.	Wrong medicine label
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.32.	Wrong/unclear strength

No.	Category	Subcategory		Details	
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.33.	Wrong drug/medicine
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.34.	Wrong/unclear indication
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.35.	Wrong/unclear rate
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.36.	Wrong/unclear administration time
21.	Medication	21.2.	Administration, Dispensing, Documentation, Monitoring, Preparation, Prescribing, Transcribing	21.2.37.	Wrong/unclear duration
22.	Communication issues	22.1.	Poor call center response		
22.	Communication issues	22.2.	Communication between staff, teams or departments		

No.	Category	Subcategory		Details
22.	Communication issues	22.3.	Communication with the patient (other than consent issues)	
22.	Communication issues	22.4.	Failure of Emergency-Call system	
22.	Communication issues	22.5.	Failure of paging system	
22.	Communication issues	22.6.	Failure of telephone system	
22.	Communication issues	22.7.	Out On Pass Policy	
22.	Communication issues	22.8.	Transport Schedule/Policy	
22.	Communication issues	22.9.	Delay of response	
22.	Communication issues	22.10.	Difficulty in communicating critical lab results	
22.	Communication issues	22.11.	Inappropriate communication	
22.	Communication issues	22.12	Inappropriate response to emergency call	
22.	Communication issues	22.13.	Incorrect interpretation	
22.	Communication issues	22.14.	Unprofessional communication	
22.	Communication issues	22.15.	Wrong information communicated	
22.	Communication issues	22.16.	Miscommunication	
22.	Communication issues	22.17.	Acceptance/ eligibility issues	
23.	Falls	23.1.	Assisted Falls	
23.	Falls	23.2.	1st fall and Assisted fall	

No.	Category	Subcategory		Details
23.	Falls	23.3.	1st fall	
23.	Falls	23.4.	Out On Pass	
23.	Falls	23.5.	Repeated and Assisted fall	
23.	Falls	23.6.	Near Fall	
23.	Falls	23.7.	Repeated falls	
23.	Falls	23.8.	From Bed	
23.	Falls	23.9.	From Chair	
23.	Falls	23.10.	From Crib	
23.	Falls	23.11.	Fall during play	
23.	Falls	23.12.	Developmental fall	
23.	Falls	23.13.	Baby child dropped	
23.	Falls	23.14.	From Exam/ Operating Table	
23.	Falls	23.15.	From Isolette	
23.	Falls	23.16.	From Lift/Hoist	
23.	Falls	23.17.	From Play Equipment	
23.	Falls	23.18.	From Stretcher	
23.	Falls	23.19.	From Toilet/ Commode	
23.	Falls	23.20.	From Radiant Warmer	
23.	Falls	23.21.	From Wheelchair	
23.	Falls	23.22.	In Shower/Tub	
23.	Falls	23.23.	On Stairs	
23.	Falls	23.24.	While Ambulating	
23.	Falls	23.25.	While Running/ Playing	

No.	Category	Subcategory		Details
23.	Falls	23.26.	Unknown/Found on Floor	
24.	Radiation treatment (Ionizing radiation Non-Ionizing (US, UV, MRI, Laser, other)	24.1.	Eye or face splash	
24.	Radiation treatment (Ionizing radiation Non-Ionizing (US, UV, MRI, Laser, other)	24.2.	Radiopharmaceuticals decay	
24.	Radiation treatment (Ionizing radiation Non-Ionizing (US, UV, MRI, Laser, other)	24.3.	Radiopharmaceuticals Expiry	
24.	Radiation treatment (Ionizing radiation Non-Ionizing (US, UV, MRI, Laser, other)	24.4.	Radiation unnecessary exposure	
24.	Radiation treatment (Ionizing radiation Non-Ionizing (US, UV, MRI, Laser, other)	24.5.	Radiopharmaceuticals mislabeling	
24.	Radiation treatment (Ionizing radiation Non-Ionizing (US, UV, MRI, Laser, other)	24.6.	Radiopharmaceuticals leakage	
24.	Radiation treatment (Ionizing radiation Non-Ionizing (US, UV, MRI, Laser, other)	24.7.	Radiopharmaceuticals wrong location	
24.	Radiation treatment (Ionizing radiation Non-Ionizing (US, UV, MRI, Laser, other)	24.8.	Radiopharmaceuticals mishandling	
24.	Radiation treatment (Ionizing radiation Non-Ionizing (US, UV, MRI, Laser, other)	24.9.	Radiopharmaceuticals missing	
24.	Radiation treatment (Ionizing radiation Non-Ionizing (US, UV, MRI, Laser, other)	24.10.	Radiation overdose	

No.	Category		Subcategory	Details
24.	Radiation treatment (Ionizing radiation Non-Ionizing (US, UV, MRI, Laser, other)	24.11.	Radiopharmaceuticals shortage	
24.	Radiation treatment (Ionizing radiation Non-Ionizing (US, UV, MRI, Laser, other)	24.12.	Radiopharmaceuticals spill	
24.	Radiation treatment (Ionizing radiation Non-Ionizing (US, UV, MRI, Laser, other)	24.13.	Radiation under-dose	
24.	Radiation treatment (Ionizing radiation Non-Ionizing (US, UV, MRI, Laser, other)	24.14.	Cluttered area	
24.	Radiation treatment (Ionizing radiation Non-Ionizing (US, UV, MRI, Laser, other)	24.15.	Poisoning	
25.	Labor and Delivery related issues	25.1.	NICU Admissions for Baby above 36wks	
25.	Labor and Delivery related issues	25.2.	Placental abruption	
25.	Labor and Delivery related issues	25.3.	Anesthetic problem connected with labor or delivery	
25.	Labor and Delivery related issues	25.4.	APGAR score less than 7 (at 5 minutes)	
25.	Labor and Delivery related issues	25.5.	Born before arrival	
25.	Labor and Delivery related issues	25.6.	Breech presentation	
25.	Labor and Delivery related issues	25.7.	Birth – Related Trauma	
25.	Labor and Delivery related issues	25.8.	Cord prolapse	

No.	Category	Subcategory		Details
25.	Labor and Delivery related issues	25.9.	Undiagnosed cephalo-pelvic disproportion	
25.	Labor and Delivery related issues	25.10.	Elective Caesarean Section	
25.	Labor and Delivery related issues	25.11.	Emergency Caesarean Section	
25.	Labor and Delivery related issues	25.12.	Difficult delivery	
25.	Labor and Delivery related issues	25.13.	Shoulder dystocia	
25.	Labor and Delivery related issues	25.14.	Fetal distress with Poor Outcome	
25.	Labor and Delivery related issues	25.15.	Labor assisted by forceps	
25.	Labor and Delivery related issues	25.16.	Unplanned home birth	
25.	Labor and Delivery related issues	25.17.	Delivery using more than one instrument	
25.	Labor and Delivery related issues	25.18.	Intrapartum hemorrhage	
25.	Labor and Delivery related issues	25.19.	IUGR or placental insufficiency	
25.	Labor and Delivery related issues	25.20.	Prolonged first or second stage of labor	
25.	Labor and Delivery related issues	25.21.	Injury or poor outcome for the mother	
25.	Labor and Delivery related issues	25.22.	Labor or delivery – other	
25.	Labor and Delivery related issues	25.23.	Delivery with PH < 7	
25.	Labor and Delivery related issues	25.24	Post-partum hemorrhage > 1,000ml	

No.	Category	Subcategory		Details
25.	Labor and Delivery related issues	25.25.	Pre-eclampsia	
25.	Labor and Delivery related issues	25.26.	Placenta Previa	
25.	Labor and Delivery related issues	25.27.	Ruptured uterus	
26.	Supply Chain issues (logistics)	26.1.	Non availability of medical items in store	
26.	Supply Chain issues (logistics)	26.2.	Non-Availability of Non-Stock Items	
26.	Supply Chain issues (logistics)	26.3.	Non availability of furniture items	
26.	Supply Chain issues (logistics)	26.4.	Non authorized property movement	
26.	Supply Chain issues (logistics)	26.5.	Overstock of medical items in wards	
26.	Supply Chain issues (logistics)	26.6.	Unregistered medical device	
26.	Supply Chain issues (logistics)	26.7.	Damaged Items When Delivered	
26.	Supply Chain issues (logistics)	26.8.	Delayed medical items delivery response	
26.	Supply Chain issues (logistics)	26.9.	Lack of stationary items supplies	
26.	Supply Chain issues (logistics)	26.10.	Medication Out of stock	
26.	Supply Chain issues (logistics)	26.11	Medical items alerts/recalls	
27.	Laundry services	27.1.	Dirty linen not collected	
27.	Laundry services	27.2.	Lack of laundry services supplies	
27.	Laundry services	27.3.	Poor laundry services response	
28.	Sentinel Events	28.1.	Unexpected death	

No.	Category	Subcategory		Details
28.	Sentinel Events	28.2.	Unexpected loss of limb or function	
28.	Sentinel Events	28.3.	Wrong patient, wrong procedure or wrong site	
28.	Sentinel Events	28.4.	Retained instrument or sponge	
28.	Sentinel Events	28.5.	Serious medication error leading to death or major morbidity	
28.	Sentinel Events	28.6.	Suicide of a patient in an inpatient unit	
28.	Sentinel Events	28.7.	Maternal death	
28.	Sentinel Events	28.8.	Hemolytic blood transfusion reaction	
28.	Sentinel Events	28.9.	Air Embolism	
28.	Sentinel Events	28.10.	Death of a full term infant	
28.	Sentinel Events	28.11.	Transmission of a chronic, fatal diseases or illness as a result of infusing blood or blood products or transplanting contaminated organs or tissue	
28.	Sentinel Events	28.12.	Deviation from standard of care (e.g. Policy, procedure, protocol, delay in management) that lead to death or serious harm.	
28.	Sentinel Events	28.13.	Child/ Infant abduction	
28.	Sentinel Events	28.14.	Infant discharged to a wrong family	
28.	Sentinel Events	28.15.	Rape	

No.	Category	Subcategory			Details
28.	Sentinel Events	28.16.	Workplace violence such as assault; or homicide (willful killing) of a patient, any employee, visitor or sub-contractors while on hospital property.		
28.	Sentinel Events	28.17.	Fire: Major destruction or loss of function to the surrounding environment (natural or facility), events that result in death		
28.	Sentinel Events	28.18.	Suicide of staff, visitors, watchers anywhere on property		
28.	Sentinel Events	28.19.	Critical equipment breakdown or failure when in use		
28.	Sentinel Events	28.20.	Unintended collapse of any building or structure under construction or alteration		
28.	Sentinel Events	28.21.	Collapse or overturning of any load bearing part of any lift or lifting equipment when in use		
29.	ID/Documentation/ Consent	29.1.	ID	29.1.1.	Absent
29.	ID/Documentation/ Consent	29.1.	ID	29.1.2.	Illegible
29.	ID/Documentation/ Consent	29.1.	ID	29.1.3.	Wrong MRN
29.	ID/Documentation/ Consent	29.1.	ID	29.1.4.	Wrong Name
29.	ID/Documentation/ Consent	29.1.	ID	29.1.5.	Wrong Patient
29.	ID/Documentation/ Consent	29.2.	Consent	29.2.1.	Abbreviation Used
29.	ID/Documentation/ Consent	29.2.	Consent	29.2.2.	None
29.	ID/Documentation/ Consent	29.2.	Consent	29.2.3.	Unsigned

No.	Category	Subcategory			Details
29.	ID/Documentation/ Consent	29.2.	Consent	29.2.4.	Wrong Procedure Listed
29.	ID/Documentation/ Consent	29.2.	Consent	29.2.5.	Wrong Patient
29.	ID/Documentation/ Consent	29.2.	Consent	29.2.6.	Wrong Side/Site Listed
29.	ID/Documentation/ Consent	29.2.	Consent	29.2.7.	Wrong Signature
29.	ID/Documentation/ Consent	29.3.	DNR	29.3.1.	Absent
29.	ID/Documentation/ Consent	29.3.	DNR	29.3.2.	Incomplete
29.	ID/Documentation/ Consent	29.3.	DNR	29.3.3.	Unclear
29.	ID/Documentation/ Consent	29.3.	DNR	29.3.4.	Unsigned
29.	ID/Documentation/ Consent	29.4	Documentation	29.4.1.	Altered
29.	ID/Documentation/ Consent	29.4.	Documentation	29.4.2.	Illegible
29.	ID/Documentation/ Consent	29.4.	Documentation	29.4.3.	Inadequate
29.	ID/Documentation/ Consent	29.4.	Documentation	29.4.4.	Inappropriate
29.	ID/Documentation/ Consent	29.4.	Documentation	29.4.5.	Incorrect
29.	ID/Documentation/ Consent	29.4.	Documentation	29.4.6.	Misfiling
29.	ID/Documentation/ Consent	29.4.	Documentation	29.4.7.	Legal Guardian Signature Missing
29.	ID/Documentation/ Consent	29.4.	Documentation	29.4.8.	Unsigned Notes
29.	ID/Documentation/ Consent	29.4.	Documentation	29.4.9.	Unsigned Telephone Order
29.	ID/Documentation/ Consent	29.4.	Documentation	29.4.10.	Wrong Addressograph

7.5 Level of Harm:

7.5.1. For medication related Incidents:

Category	Description
A	Circumstances or events that have the capacity to cause error**.**
B	An error occurred but the error did not reach the patient**.**
C	An error occurred that reached the patient but **did not cause patient harm.**
D	An error occurred that reached the patient and required monitoring to confirm that it resulted in **no harm** to the patient and/or **required intervention to preclude harm.**
E	An error occurred that may have contributed to, or resulted in **temporary harm** (minor injury) to the individual and required intervention.
F	An error occurred that may have contributed to, or resulted in **temporary harm** (minor injury) to the individual and required **intervention and initial or prolonged hospitalization.**
G	An error occurred that may have contributed to, or resulted in individual harm **(serious injury - prolonged the stay or extensive follow up).**
H	An error occurred that resulted in **life-threatening injury or multiple serious** injuries causing hospitalization and required intervention necessary to **sustain life.**
I	An error occurred that may have contributed to or resulted in the **patient's death**.

7.5.2. Level of Other Types of Incidents:

Level	Matching with medication related Incident	Definition
None	**A-D**	Incident occurred with no harm to the patient or person involved.
Minor	**E-F**	No change in vital signs. Non-invasive diagnostic test required. Increased observation or monitoring required.
Moderate	**G**	Vital signs changes. Decreased level of consciousness. Additional medication/treatment required. Invasive diagnostic procedure required.
Major	**H**	Any unexpected or unintended incident that caused permanent or long-term harm to one or more persons.
Catastrophic	**I**	Incident resulting in death.

08

Acknowledgements

This document is a **joint authorship between all Healthcare sectors and healthcare organizations in Saudi Arabia**, as well as, from published researches worldwide. We are grateful to all those from within the healthcare sector for their contribution.

Ministry of Health- Riyadh
Name - Mr. Abdulaziz Abdulbaqi
Role - *Sponsor*

Saudi National Patient Safety Center
Name - Dr. Abdulelah Mohammad Alhawsawi
Role - *Sponsor*

King Fahad Medical City
Name - Dr. Adel Bataweel
Role - *Chairman*

King Faisal Sociality Hospital and Research center (KFSH&RC)
Name - Dr. Abier Hamami
Role - *Co/Chair*

Security Forces
Name - Mr. Zyad S. Al Daham
Role - *Member*

Armed Forces Hospital Southern Region
Name - Mr. Bahaee Saleh
Role - *Member*

Al Amal Medical Complex
Name - Dr. Hadeel Daghash
Role - *Member*

King Khalid University Hospital
Name - Dr. Ala'a Abu Al Rub
Role - *Member*

Ministry of National Guard
Name - Rph. Susan Al Owais
Role - *Member*

Ministry of Health
Name - Dr. Abdulrhamn Al Bawardi
Role - *Member*

Primary Care Centers - MOH
Name - Dr. Ahlam Danish
Role - *Member*

King Abdulaziz Specialist Hospital
Name - Dr. Munis Bawazeer
Role - *Member*

CBAHI
Name - Dr. Magid Al Magrabi
Role - *Member*

International Medical Center
Name - Ms. Rouba Smia
Role - *Member*

Ministry of Health
Name - Ms. Haifa Al Naimi
Role - *Project Manager*

Health Matrix
Name - Ashraf Marwan Shana'ah
Role - *Project Manager*

Health Matrix
Name - Anas Abdrabbo
Role - *Member*

Thanks and Appreciation To HealthMatrix
For For their valuable contribution in the taxonomy project

09

Appendix

References

09 References

Agency for Healthcare Research and Quality. (n.d). PSNet Glossary.
Available at: https://psnet.ahrq.gov/glossary/p [Accessed 12 Sep. 2017]

American Society of Health-System Pharmacists, (1993). ASHP guidelines on preventing medication errors in hospitals. American Journal of Health-System Pharmacy, 50(2), pp.305-314.

Center of Disease Control and Prevention. (2012). Surgical Site Infection (SSI) | HAI | CDC. [online] Cdc.gov.
Available at: https://www.cdc.gov/hai/ssi/ssi.html [Accessed 12 Sep. 2017]

Chang, A., Schyve, P.M., Croteau, R.J., O'leary, D.S. and Loeb, J.M., (2005). The JCAHO patient safety event taxonomy: a standardized terminology and classification schema for near misses and adverse events International Journal for Quality in Health Care, 17(2), pp.95-105.

Definitions of Key Concepts from the WHO Patient Safety Curriculum Guide (2011). 1st ed. [ebook] WHO.
Available at: http://www.who.int/patientsafety/education/curriculum/course1a_handout.pdf
[Accessed 12 Sep. 2017].

Department of Health (2015). Mandatory Reporting Overview PHC Remote Guideline.
Available at: http://remotehealthatlas.nt.gov.au/mandatory_reporting_overview.pdf. [Accessed 12 Sep. 2017]

Donaldson, M.S., Corrigan, J.M. and Kohn, L.T. eds., (2000). To err is human: building a safer health system
(Vol. 6). National Academies Press.

Elden, N.M.K. and Ismail, A., (2016). The Importance of Medication Errors Reporting in Improving the Quality of Clinical Care Services. Global journal of health science, 8(8), p.243.

Holdford, D.A. and Brown, T.R. eds., (2010). Introduction to hospital and health-system pharmacy
practice. ASHP.

Institute for Safe Medication Practices. (2011). Institute for Safe Medication Practices Medication Safety Self Assessment for Hospitals.
Available at: http://www.ismp.org/selfassessments/hospital/2011/definitions.pdf
[Accessed 12 Sep. 2017]

International Organization for Standardization. (n.d). Terms and definitions of ISO27005.
Available at: http://www.iso270012013.info/news-articles/resources/terms-and-definitions-of-iso27005.aspx
[Accessed 12 Sep. 2017]

Investopedia Academy (n.d.). Quality Management. [online] Investopedia Academy.
Available at: http://www.investopedia.com/terms/q/quality-management.asp
[Accessed 12 Sep. 2017]

Joint Commission International (2017). Joint Commission International Accreditation Standards for Hospitals.
6th ed. Oak Brook: Joint Commission Resources. 327-338.

Kizer, K.W. and Stegun, M.B., (2005). Serious reportable adverse events in health care.

NAPUAP. (2016). National Pressure Ulcer Advisory Panel (NPUAP) announces a change in terminology from pressure ulcer to pressure injury and updates the stages of pressure injury | The National Pressure Ulcer Advisory Panel - NPUAP. [online] Npuap.org.
Available at: http://www.npuap.org/national-pressure-ulcer-advisory-panel-npuap-announces-a-change-in-terminology-from-pressure-ulcer-to-pressure-injury-and-updates-the-stages-of-pressure-injury
[Accessed 12 Sep. 2017]

National Coordination Council for Medication Error Reporting and Prevention. (n.d). NCC MERP Taxonomy of Medication Errors1.
Available at: http://www.nccmerp.org/sites/default/files/taxonomy2001-07-31.pdf
[Accessed 12 Sep. 2017]

Near fall. (n.d.) Medical Dictionary. (2009).
Available at: http://medical-dictionary.thefreedictionary.com/near+Fall [Accessed 12 Sep. 2017]

Newsome, B., (2013). A practical introduction to security and risk management. SAGE Publications.

O'Leary, M.R., (2006). The dictionary of homeland security and defense. iUniverse.

Oregon.gov. (n.d.). Insurance clauses - Pollution liability. [online]
Available at: http://www.oregon.gov/das/Risk/Pages/InsclausesPollutLiab.aspx
[Accessed 12 Sep. 2017]

Polovich, M., Whitford, J. and Olsen, M., 2008. Chemotherapy and biotherapy guidelines and recommendations for practice. Oncology Nursing Society.

Praxiom Research Group Limited. (2010). Plain English ISO 31000 2009 Risk Management Dictionary.
Available at: http://praxiom.com/iso-31000-terms.htm [Accessed 12 Sep. 2017]

Praxiom Research Group Limited. (2017). ISO 9000 2015 Plain English Definitions.
Available at: http://www.praxiom.com/iso-definition.htm [Accessed 12 Sep. 2017]
Runciman, W., Hibbert, P., Thomson, R., Van Der Schaaf, T., Sherman, H. and Lewalle, P., (2009). Towards an International Classification for Patient Safety: key concepts and terms. International journal for quality in health care, 21(1), pp.18-26.

Saudi Central Board for Accreditation of Healthcare Institutions (2015). National Hospital Standards. 3rd ed. Jeddah: CBAHI. 31.

Spath, P.L., (2012). Error reduction in health care: a systems approach to improving patient safety. Journal of Nursing Regulation, 2(4), p.60.

The Institute for Healthcare Improvement (IHI) and the National Patient Safety Foundation (NPSF). (n.d). Patient Safety Dictionary.
Available at: http://www.npsf.org/?page=dictionarynz [Accessed 12 Sep. 2017]

U.S. Department of Health & Human Services. Agency for Healthcare Research and Quality. (n.d) United States Health Knowledgebase. Unassisted or assisted fall. DE192
Available at: https://ushik.ahrq.gov/ViewItemDetails?system=ps&itemKey=88779000 [Accessed 12 Sep.2017]

World Alliance For Patient Safety Drafting Group, Sherman, H., Castro, G., Fletcher, M., Hatlie, M., Hibbert,
P., Jakob, R., Koss, R., Lewalle, P., Loeb, J. and Perneger, T., (2009). Towards an International Classification

for Patient Safety: the conceptual framework. International Journal for Quality in Health Care, 21(1), pp.2-8.

World Health Organization. (2002). Glossary.
Available at: http://apps.who.int/medicinedocs/en/d/Js4893e/9.html [Accessed 12 Sep. 2017]

World Health Organization. (2009). Glossary of Patient Safety Concepts and References.
Available at: http://www.who.int/patientsafety/taxonomy/icps_technical_annex2.pdf [Accessed 12 Sep. 2017]