




Safety Alert System (SAS)

Category Description


As of 2/22/2017

GENERAL EVENT TYPE	DESCRIPTION	SPECIFIC EVENT TYPE	PERSON AFFECTED
<p>Employee Event</p> 	<p>For <u>any</u> safety event where the affected person is an <u>employee</u></p>	<p>Allergic Reaction Back Injury Burn Caught in/on/Between Electrocutation Exposure to Blood/Body Fluid (non needlestick) Exposure to Communicable Disease Exposure to Other Hazardous Material Fall/Slip/Trip Medical Emergency Needlestick/Sharps Issue Respiratory Issues Skin Tear/Cut Strain/Sprain Traffic Accident Other</p>	<p>Employee Volunteer</p>
<p>Adverse Drug Reaction</p> 	<p>For events related to patients' negative reaction to drugs/medication</p>	<p>Allergy Unknown to Patient Drug - Drug Interaction Drug - Food Interaction Drug - Dietary Supplement interaction Drug - Disease Interaction Other</p>	<p>In-Center Patient Home Hemo Patient PD Patient Multiple Patients Hospitalized Patient</p>
<p>CPR/Airway Management</p> 	<p>For events involving patient breathing problems or when CPR is admitted</p>	<p>Airway Mgmt Equipment Issue Airway Obstructed CPR with AED Performed CPR without AED Performed CPR Delayed/inadequate AED failure Delivery Mode Incorrect Oxygen not available Rate/Flow/Concentration Incorrect Respiratory Mgmt – Delayed; Inappropriate Other</p>	<p>In-Center Patient Home Hemo Patient PD Patient Multiple Patients Hospitalized Patient</p>

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<p>Blood Product</p> 	<p>For events involving blood products or handling of blood products</p>	<p>Adverse Reaction Consent Issue Contraindication Device Failure/Malfunction Dislodgement/Misconnection/ Removal Frequency Incorrect Incorrect Volume (ie: # of Units or Milliliters) Incorrect Rate Patient - Wrong Requested (Patient - Wrong Transfused Patient - Incorrectly Collected Process Issue Product - ABO Blood Complication (Wrong Blood Type) Product - Expired Product - Wasted Product - Wrong Component Issued Product - Wrong Component Requested Product - Wrong Type of Blood Product Storage Incorrect Transfusion Issue - Acceptable Time Frame/Expired Transfusion Issue - Not Started When Product Received Transfusion Issue - Pre-Transfusion Checks Not Done Prior to Release Transfusion Issue- Monitoring Error Unit Mismatched User Error Other Unknown</p>	<p>In-Center Patient Home Hemo Patient PD Patient Multiple Patients Hospitalized Patient</p>

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<p>Dialysis/Treatment</p> 	<p>For events during patient dialysis treatment / associated with patient dialysis treatment</p>	<p>Adverse Reaction (Non Med) Allergic Reaction (Non Med) Access- lines disconnected Access- Catheter dislodgement Access- Needle Dislodgement Access- Needle Dislodgement w/ blood loss Failure to Assess Patient Patient Left Against Medical Advice Isolation - Failure to Follow Protocol Treatment - Delay/Lack of Response to Patient Condition Treatment - Incorrectly Performed Treatment - Errors of Omission/Delay Resulting in Death or Serious Injury Treatment - Wrong Dialyzer Treatment - Dialysate Treatment- Death- comfort care only Line Backwards Treatment-Defective tubing Treatment- Medical Condition Treatment- Clotted system Treatment- Blood Loss post treatment Treatment - Wrong Dialysate Treatment- restraints Treatment - Wrong Patient Treatment- wrong needle size Treatment- Prescription not followed Treatment- Mandatory Machine Checks not completed Treatment- Mandatory Patient Monitoring not completed Water- Delivery Issue Water- RO issue Water- Testing Issue Other</p>	<p>In-Center Patient Home Hemo Patient PD Patient Multiple Patients Hospitalized Patient</p>

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<p>Equipment/Medical Device</p> 	<p>Problems with medical equipment or devices</p>	<p>Broken Item Disconnected In-Center Equipment Malfunction Home Hemo Equipment Malfunction PD equipment Malfunction RO Equipment Malfunction Refrigeration Malfunction Electrical Issue Equipment - Faulty Equipment - Not Available Outdated Item Preventative maintenance Issue Sterilization/Cleanliness Issue Water Room Equipment Malfunction Other</p>	<p>In-Center Patient Home Hemo Patient PD Patient Multiple Patients Hospitalized Patient</p>
<p>Facilities</p> 	<p>For events associated with facility hazards, faulty equipment, structures, etc.</p>	<p>Air Quality Blocked/Obstructed Hallway/Sidewalk/Stairway Cleanliness of Facility Communications Down Construction Dust Issue Disaster-External or Internal Elevator Malfunction Emergency Exits Blocked Equipment Issue Improper Storage Lighting of Facility/Parking Areas Noise Level of Facility Power Outage Provision of Handicapped Access Spill Temperature of Facility Unsafe Condition Not Posted Walking Surface Issue Water Leak/Flood Water delivery system issue Other (please specify)</p>	<p>In-Center Patient Home Hemo Patient PD Patient Multiple Patients</p>

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<p>Patient/Visitor Fall</p> 	<p>Patient or Visitor Falls</p>	<p>From Bed From Bedside From Chair From Equipment From Exam Stool From Gerichair From Lift From Stretcher From Toilet/In Bathroom From Wheelchair Outside On Grounds of Facility While Ambulating While Weighing at the scale While Transferring Other (please specify) Unknown/Found on Floor</p>	<p>In-Center Patient Home Hemo Patient PD Patient Multiple Patients Hospitalized Patient Visitor</p>
<p>Patient Behavior</p> 	<p>Safety events associated with patient behavior (disruptive, outburst, dangerous behavior, etc.)</p>	<p>Patient Behavior</p>	<p>In-Center Patient Home Hemo Patient PD Patient Multiple Patients Hospitalized Patient</p>
<p>Patient Grievance</p> 	<p>Informal/Formal or Written/Unwritten complaint from Patients, Family Members, Visitors</p>	<p>Family Member Grievance Patient Grievance Visitor Grievance</p>	<p>In-Center Patient Home Hemo Patient PD Patient Multiple Patients Hospitalized Patient</p>

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<p>Healthcare IT</p> 	<p>IT Security; PHI Risks/Breach</p>	<p>Network Failure or Problem Virus or Other Malware Issue Application Event Security Event Intrusion/Breach Event DLP Event Firewall Event Vendor Related Event Other</p>	<p>In-Center Patient Home Hemo Patient PD Patient Multiple Patients</p>
<p>Infection</p> 	<p>Safety events related to patient infection or possible exposure</p>	<p>Hand Hygiene Compliance Issue Isolation - Breach Isolation - Failure to Follow Protocol Patient Exposure - Blood/Body Fluid Patient Exposure - Communicable Disease Patient Exposure - Other Contaminated Material Patient Exposure - Sharps Issue Sterilization/Disinfection Issue Suspected Infection Other</p>	<p>In-Center Patient Home Hemo Patient PD Patient Multiple Patients Hospitalized Patient Visitor</p>
<p>Lab/Specimen</p> 	<p>Safety events concerning Lab/Specimen collection, ordering, processing</p>	<p>Collection Issue Labeling Issue Documentation - Consent Issue Documentation - Wrong Patient Selected Ordering Issue Patient ID Issue Reporting Issue - Call Not Documented Reporting Issue Not Called Results Issue Specimen Acceptability Issue Specimen Processing Issue Specimen Processing – Delivery, Delay problem Specimen Lost Specimen Processing - Specimen Misplaced Specimen Processing - Specimen Storage Requirements Not Met Supply Issue Testing Issue - Not Performed, Wrong Test</p>	<p>In-Center Patient Home Hemo Patient PD Patient Multiple Patients Hospitalized Patient</p>

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<p style="text-align: center;">Medication</p> 	<p style="text-align: center;">For medication-related events that occur <u>in the dialysis units/centers</u></p>	<p>ORDER ENTRY</p> <ul style="list-style-type: none"> Patient Incorrect Medication Incorrect Contraindicated-Drug-Drug Contraindicated-Drug-Food Contraindicated- Drug-Disease Contraindicated-Known Allergy Regulatory Noncompliance Dose Incorrect Dosage Form Incorrect Route Incorrect Quantity/Duration Incorrect Directions Incorrect Incorrect time Monitoring Issue <p>MEDICATION PROCESS</p> <ul style="list-style-type: none"> Medication Not Ordered Medication not available from supplier Medication Stored Incorrectly Medication ordered but not administered Medication administered but not ordered Controlled Substance Inventory Variance <p>MEDICATION ADMINISTRATION</p> <ul style="list-style-type: none"> Dosage form Incorrect Dose Incorrect Medication Incorrect Patient Incorrect Route Incorrect Timing Incorrect Medication Refused Administration Technique Incorrect 	<ul style="list-style-type: none"> In-Center Patient Home Hemo Patient PD Patient Multiple Patients Hospitalized Patient

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<p style="text-align: center;">Pharmacy</p> 	<p style="text-align: center;">For medication-related events that occur <u>in the pharmacy</u></p>	<p>PRESCRIBING</p> <ul style="list-style-type: none"> Patient Incorrect Medication Incorrect Contraindicated-Drug-Drug Contraindicated-Drug-Food Contraindicated- Drug-Disease Contraindicated-Known Allergy Regulatory Noncompliance Dose Incorrect Dosage Form Incorrect Route Incorrect Quantity/Duration Incorrect Directions Incorrect Monitoring Issue Refills Incorrect <p>FILLING</p> <ul style="list-style-type: none"> Medication Incorrect Medication Expired Medication Recalled NDC Incorrect Dose Incorrect Dosage Form Incorrect Quantity Incorrect <p>DISPENSING/DELIVERY</p> <ul style="list-style-type: none"> Patient Incorrect Patient counseling Inadequate Delivery Method Incorrect Dialysis Unit Incorrect Mailing address Incorrect Delivery delay/failure Courier Delay Monitoring Issue <p>MEDICATION PROCESS</p> <ul style="list-style-type: none"> Medication Not Ordered Medication not available from supplier Medication Stored Incorrectly Prescription ordered but not filled Prescription filled but not ordered 	<ul style="list-style-type: none"> In-Center Patient Home Hemo Patient PD Patient Multiple Patients Employee CKD Transplant

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<p>Pharmacy Continued</p>		<p>Controlled Substance Inventory Variance</p> <p>ORDER ENTRY</p> <p>DAW Incorrect</p> <p>Directions Incorrect</p> <p>Dosage form Incorrect</p> <p>Dose Incorrect</p> <p>Medication Incorrect</p> <p>Patient Incorrect</p> <p>Quantity Incorrect</p> <p>Refills Incorrect</p> <p>Regulatory Noncompliance</p> <p>PATIENT</p> <p>Administration Technique Incorrect</p> <p>Medication Taken Incorrectly- Under dose</p> <p>Medication Taken Incorrectly- Overdose</p> <p>Medication Stored Incorrectly</p> <p>Medication Refused</p>	
<p>Good Catch</p> 	<p>For near misses or close calls that could have resulted in an incident</p>	<p>(Submitter provides description)</p>	<p>In-Center Patient</p> <p>Home Hemo Patient</p> <p>PD Patient</p> <p>Multiple Patients</p> <p>Employee</p> <p>Hospitalized Patient</p> <p>Location/Person Not Applicable</p>

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<p>Patient and Staff Security</p> 	<p>For any actual or suspected threat or harm to patients, visitors, staff</p>	<ul style="list-style-type: none"> Abandonment Abduction Abuse/Assault (Physical) Abuse/Assault (Verbal) Accidental Injury of Unknown Origin Auto Accident Bomb Threat Breach of Confidentiality Breach of Privacy Chemical Spill Disaster Code Disorderly Person Domestic Quarrel Equipment Malfunction Evacuation Code Fire/Fire Alarm Hostage Taking Lost Health Record/Chart Missing/Wandering Patient/Resident Property Damage/Vandalism Property Lost Safety Policy Violation Self-Injury Smoking Stalking Suicide Suicide Attempt Suspicious Package Theft/Suspected Theft Threat of Violence Unauthorized Access/Trespassing Unauthorized Drugs Unauthorized Equipment Unauthorized Person Weapons on Premises Other 	<ul style="list-style-type: none"> In-Center Patient Home Hemo Patient PD Patient Multiple Patients Employee Visitor Hospitalized Patient