SEC Safety Event Classification®

HPI

A deviation from generally accepted performance standards (GAPS) that…

Serious Safety Event

- Reaches the patient
- Results in moderate to severe harm or death,

Precursor Safety Event

- Reaches the patient
- Results in minimal harm or no detectable harm

Near Miss Safety Event

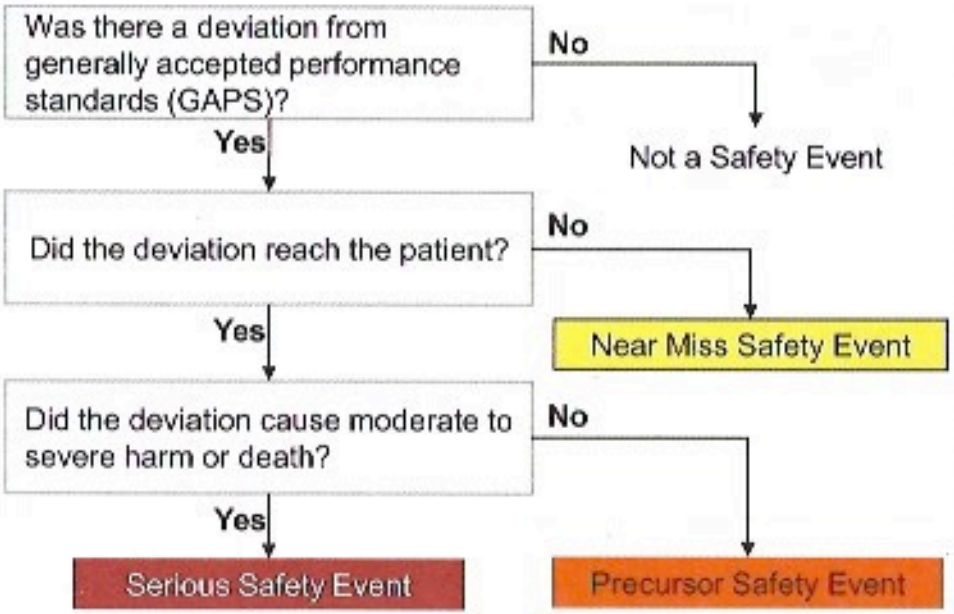
- Does not reach the patient
- Error is caught by a detection barrier or by chance

HPI

The SEC Algorithm

SEC Safety Event Classification®

HPI



Identifying Deviations from GAPS

Deviations from generally accepted performance standards are determined by comparing actual performance to expected performance. ***Internal practice expectations do not always reflect industry practice expectations in protecting workers from harm.*** Consideration of performance expectations should include external as well as internal sources such as:

- Internal policies, procedures, or protocols
- Nationally recognized best practices and standards of care
- Industry-imposed practice mandates and requirements
- Professional practice standards
- Objective review by other experts
- Organization's obligation to best protect the worker from harm

If any of the above are answered yes, proceed with safety events classification.

Considering "Known Complications"

*A **known complication** is an adverse outcome supported in literature as a potential risk related to a procedure, treatment, or test that is not present before the patient care encounter and occurs as a result of patient care.*

If an event is perceived to be a known complication, the Known Complications Test can be used to confirm the event as a complication and to determine if providers did everything possible to prevent the negative outcome. If the patient experienced a "known complication," consider the following:

1. Was the procedure, treatment, or test appropriate and warranted based on nationally recognized standards of care?
2. Was the complication a known risk, was it anticipated before to procedure, and was the standard of care applied to mitigate the risk?
3. Was the complication identified in a timely manner (i.e. at the time of the occurrence)?
4. Was the complication treated according to the standard of care and in a timely manner?

If the answer to all 4 questions is yes, the event is considered a known complication and not a Safety Event. If the answer to any question is no, the event is a Safety Event. Proceed in defining the classification based on the level of harm to the patient.

HPI Safety Event Classification[SM] (SEC) Levels of Harm

Safety Event classification applies if a deviation from Generally Accepted Performance Standards (GAPS) causes, or results in, the event

	Code	Level of Harm	Description
Serious Safety Event	SSE 1	Death	A deviation in GAPS resulting in death
	SSE 2	Severe Permanent Harm	A deviation in GAPS resulting in critical, life-changing harm with no expected change in clinical status; includes events resulting in permanent loss of organ, limb, or vital physiologic or neurologic function Example - Wrong site procedure resulting in removal of healthy limb - Missed diagnosis of stroke resulting in permanent impairment - Uterine rupture resulting in loss of uterus - Anoxic brain injury resulting in permanent brain damage - Incorrect radiologic contrast dosing resulting in need for permanent dialysis
	SSE 3	Moderate Permanent Harm	A deviation in GAPS resulting in significant harm with no expected change in clinical condition yet not sufficiently severe to impact activities of daily living or business functioning; includes events that result in permanent reduction in physiologic reserve, disfigurement, and impaired or aided sense or function Examples - Incorrect radiology contrast dosing resulting in reduced renal function - Inadvertent injury to spleen during abdominal surgery requiring removal of the spleen - Delay in treatment of limb ischemia requiring fasciotomy that results in minimal loss of function but disfiguring scars - Inappropriate intra-arterial medication injection resulting in loss of a finger, other than the thumb or 2nd finger which may qualify the event as SSE 2
	SSE 4	Severe Temporary Harm	A deviation in GAPS resulting in critical, potentially life-threatening harm yet lasting for a limited time with no permanent residual; requires prolonged transfer to a higher level of care/monitoring, transfer to a higher level of care for a life-threatening condition, or an additional major surgery, procedure, or treatment to resolve the condition Examples - Induced condition that requires resuscitation - Unrecognized fluid overload that progresses to pulmonary edema requiring transfer to the ICU for treatment - Failure to diagnose respiratory insufficiency resulting in temporary intubation where earlier recognition of the condition would have avoided the intubation - Preventable fall with hip fracture that requires surgical repair - Retained object that requires return to the operating room
	SSE 5	Moderate Temporary Harm	A deviation in GAPS resulting in significant harm lasting for a limited time; requires a higher level of care/monitoring or an additional minor procedure or treatment to resolve the condition Examples - Failure to treat a low potassium level that results in an arrhythmia requiring administration of intravenous anti-arrythmic drug, but with continued arrhythmia requiring extended monitoring and a higher intensity of care - Incorrect dose of dilaudid for pain resulting in over-sedation and requiring transfer to ICU for treatment and monitoring after narcan was ineffective in treating - Failure to routinely assess IV site resulting in an infection at IV site or (septic phlebitis) requiring extensive surgical incision and drainage to resolve - Incision made on the right knee instead of the left knee during an schedule knee replacement surgery

	Code	Level of Harm	Description
Precursor Safety Event	PSE 1	Minimal Permanent Harm	A deviation in GAPS resulting in minor harm with no expected change in clinical status; requires little or no intervention Examples - Inadequate protection of ulnar nerve during an operation resulting in numbness of 4th and 5th fingers - Excess radiation therapy resulting in skin color change in non-critical cosmetic area
	PSE 2	Minimal Temporary Harm	A deviation in GAPS resulting in minor harm lasting for a limited time only; requires little or no intervention Examples - Failure to assess IV site resulting in bruising or swelling - Retained sponge in vaginal cavity found and removed during office exam and resulting in no or minor infection - Administration of low dose insulin to a non-diabetic patient requiring only a glucose check and drink of orange juice - Incorrect dose of dilaudid for pain resulting in over-sedation and narcan resuscitation with immediate resolution - An anesthetic nerve block was performed on the right knee instead of the left knee in a scheduled knee replacement surgery before it was realized the wrong side had been anesthetized
	PSE 3	No Detectable Harm	A deviation in GAPS that reaches the patient yet without ability to determine the existence or fact of harm, yet harm may exist; includes events where the onset of harm may occur later in time Example - Procedure performed with un-sterile instruments with no detectable post-procedure complications or infection - Inappropriate technique resulting in losing coronary artery stent into systemic circulation with no evidence of limb or organ ischemia
	PSE 4	No Harm	A deviation in GAPS that reaches the patient yet results in no harm, with sufficient information available to determine that no harm occurred Example - Transfusion of blood intended for another patient yet of the correct blood type - Administration of an adult dose of vitamin K to a full term newborn infant with no resulting damage
Near Miss Event	NME 1	Unplanned Barrier Catch	A deviation in GAPS that passes through all error detection barriers and does not reach the patient because it is caught by chance or a barrier not designed into the system Example - Family member who reminds of a known medication allergy immediately before the medication is to be administered to the patient - Environment Services Associate points out the need to perform a time out prior to a bedside procedure resulting in awareness that the procedure was about to be performed on the incorrect limb - Food Services Associate notices pills in waste basket, thrown away by the patient, and alerts the patient's nurse who ensures medication administration
	NME 2	Last Strong Barrier Catch	A deviation in GAPS that passes through early error detection barriers and is caught by a last strong error detection barrier designed into the system Example - Medication error caught by nurse performing "5 Rights" prior to administration - Wrong patient brought to the OR and identified during the team time out
	NME 3	Early Barrier Catch	A deviation in GAPS that is caught by an early error detection barrier designed into the system's defense in depth Example - Medication error identified when a contraindication alert fires in the pharmacy order entry system - During bedside shift change report, care team identifies that multiple IV lines in a complex ICU patient are not labeled and makes the correction to minimize risk of confusion