Department: Quality Improvement Department (QID)

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DHCC outpatient clinic
Sentinel event REPORTING Form

FORM

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| DHCC Outpatient Clinic Sentinel Event Reporting Form

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| Healthcare Operator (HCO) ID Number:  |  |  |
| Healthcare Operator (HCO) Name:  |  |  |
| Date of Incident (dd/mm/yyyy): |   |  |

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| Event Type |
| € | An unanticipated death that is unrelated to the natural course of the patient’s illness or underlying condition (for example, death from a postoperative infection or a health care–associated infection) |
| € | Death of a full-term infant |
| € | Major permanent loss of function unrelated to the patient’s natural course of illness or underlyingcondition |
| € | Wrong-site, wrong-procedure, wrong-patient surgery, wrong side of the body, or wrong organ |
| € | Transmission of a chronic or fatal disease or illness as a result of infusing blood or blood products ortransplanting contaminated organs or tissues |
| € | Hemolytic transfusion reaction involving major blood group incompatibilities |
| € | Infant abduction or an infant sent home with the wrong parents |
| € | Rape, workplace violence such as assault (leading to death or permanent loss of function), or homicide(willful killing) of a patient, staff member, practitioner, medical student, trainee, visitor, or vendorwhile on organization property |
| € | Medication error resulting in patient death, paralysis, coma, or other major permanent loss of function |
| € | Anesthesia-related event resulting in patient death, paralysis, coma, or other major permanent loss of function |
| € | Suicide / Suicide of a patient in a setting where the patient is housed around-the-clock, or suicide following elopement (unauthorized departure) from such a setting |
| € | Patient fall that results in patient death, paralysis, coma or other major permanent loss of function as a direct result of the injuries sustained in the fall |
| € | Infection-related event resulting in patient death, paralysis, coma, or other major permanent loss of function |
| € | Delay in treatment resulting in patient death, paralysis, coma, or other major permanent loss of function |
| € | Use of restraints resulting in patient death, paralysis, coma, major permanent loss of function, or injury |
| € | Medical equipment / ventilator-related malfunction or misuse resulting in patient death, paralysis, coma, or other major permanent loss of function |
| € | Op/post-op complication resulting in patient death, paralysis, coma, or other major permanent loss of function |
| € | Utility systems (electricity, water, gas) related event resulting in patient death, paralysis, coma, or other major permanent loss of function |
| € | Other event resulting in unanticipated patient death, paralysis, coma, or other major permanent loss of function (unrelated to the natural course of the patient’s illness or underlying condition) |

Summary of event: (Please describe the event. Do not include the name(s) of staff, patient(s), or other individual(s) involved in the event)

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| HCO Quality and Patient Safety Contact Person Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| E-mail Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Fax No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  Date (dd/mm/yyyy):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Please deliver this completed, signed DHCC Sentinel Event Reporting Form to the Quality Improvement Department (QID) at Dubai Healthcare City Authority Regulatory (DHCR) within 24 hours of the event occurrence.For all correspondence please use the following information:Quality Improvement Department DHCRIbn Sina Building 27 - Ground Floor, Building CDubai Healthcare CityTelephone Number: 04 3838300Email: QID@dhcr.gov.ae |