

**The following definitions are found in the Patient Safety Program and Policy:**

**Sentinel Event-** An unexpected event has resulted in an unanticipated death, serious physical or psychological injury or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition, or the event is one of the following (even if the outcome was not death or major permanent loss of function):

- suicide of a patient in a setting where the patient receives around-the-clock care
- infant abduction or discharge to the wrong family
- rape , as defined by SC law
- hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
- surgery on the wrong patient or wrong body part, regardless of the procedure

**Adverse or Serious Event-** an untoward incident, therapeutic misadventure, iatrogenic injury or other unexpected occurrence that does not achieve its intended outcome but does not meet the definition of a Sentinel Event and is directly associated with the care of services provided within MUSC Medical Center.

**Unanticipated Outcome-** is a result that differs significantly from what was anticipated to be the result of a treatment or procedure. An unanticipated outcome may or may not include error. A known complication or side effect is not an unanticipated outcome, but information about such outcomes should also be provided out of respect for the patients.

**Error-** an unintended act, either of omission or commission,

**Hazardous Condition-** any set of circumstances (exclusive of the disease or condition for which the patient is being treated) which significantly increases the likelihood of a serious adverse outcome.

**Near Miss-** any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of serious adverse outcome. An event or situation directly associated with care or services provided within the organization that could have resulted in an accident, injury or illness, but did not, either by chance or

through timely interventions. Near misses do not affect the patient's plan of care but a recurrence would carry a significant chance of impacting another patient's plan of care.

**Failure Mode and Effect Analysis-** a process for identifying and improving those critical points in a process that are necessary to reasonable ensure a safe and clinically desirable outcome.

**Root Cause Analysis-** a process for identifying the base of contributing causal factors that underlie variations in performance associated with Adverse Event, Sentinel Events or Near Misses.