Appendix G. Incident Definitions (Based on MERS-TM & TESS)

Incident Result

No Recovery, harm
A product related to this incident was transfused; the patient experienced an adverse reaction.

No Recovery, no harm
A product related to this incident was transfused; the patient did not experience an adverse reaction.

Near miss, unplanned recovery
No product related to this incident was transfused; the incident was discovered ad hoc, by accident, by human lucky catch, etc.

Near miss, planned recovery
No product related to this incident was transfused; the incident was discovered through a standardized process or barrier designed to prevent errors.

Root Cause Analysis Result(s)

Technical:
- Technical failures beyond the control and responsibility of the facility.
- Poor design of equipment, software, labels or forms.
- Designed correctly but not constructed properly or set up in accessible areas.
- Other material defects.

Organizational:
- Failure at an organizational level beyond the control and responsibility of the facility or department where the incident occurred.
- Inadequate measures taken to ensure that situational or domain-specific knowledge or information is transferred to new or inexperienced staff.
- Inadequate quality and/or availability of protocols or procedures within the department (e.g., outdated, too complicated, inaccurate, unrealistic, absent or poorly presented).
- Organizational/cultural attitudes and behaviors. For example, internal management decisions when faced with conflicting demands or objectives; an inadequate collective approach and its attendant modes of behavior to risks in the investigating organization.

Human:
- Human failures originating beyond the control and responsibility of the investigating organization. This could include individuals in other departments.
- Inability of an individual to apply their existing knowledge to a novel situation.
- An incorrect fit between an individual's training or education and a particular task.
- A lack of task coordination within a health care team.
- Incorrect or incomplete assessment of a situation including related conditions of the patient and materials to be used before starting the transfusion. Faulty task planning and execution. Example: washing red blood cells using the same protocol as that used for platelets.
- Failure in monitoring a process or patient status.
- Failure in performing highly developed skills.
- Failure in whole body movements, e.g. slips, trips and falls.

Patient-related:
- Failures related to patient characteristics or conditions which are beyond the control of staff and influence treatment.

Other:
- Cannot be classified under any of the other categories.