



Office of Health Standards Compliance
Ensuring quality and safety in health care

EARLY WARNING SYSTEM INDICATORS

Critical indicators

| 1 | Abbreviated Name | Missing minor |
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| | Indicator | Number of reported incidents where a new-born or child (up to 13 years) went missing in a health establishment |
| | Numerator | Number of reported incidents where a new-born child (up to 13 years) went missing |
| | Denominator | None |
| | Regulation | 17(1) The Health establishment must have systems to protect users, health care personnel and property from security threats and risks |
| | Short definition | Missing minor (new-born to children up to 13 years of age) in a health establishment |
| | Reporting requirement | Reported within 24 hours of the health establishment becoming aware of the incident |
| | Indicator type | Incident report |
| | Applicability | All health establishments |
| | Inclusion | All minors reported missing in a health establishment (inpatient/outpatient/visitors/minors accompanying adults) |
| | Exclusion | None |
| 2 | Abbreviated Name | Abscondment of a patient |
| | Indicator | Number of reported incidents where patient abscondment occurred in a health establishment |
| | Numerator | Number of reported incidents where patient abscondment occurred |
| | Denominator | None |
| | Regulation | 17(1) The Health establishment must have systems to protect users, health care personnel and property from security threats and risks |
| | Short definition | In-patient who abscond from a health establishment |
| | Reporting requirement | Reported within 24 hours of the health establishment becoming aware of the incident |
| | Indicator type | Incident report |
| | Applicability | Health establishments with admission facilities |
| | Inclusion | All patients who abscond irrespective of the diagnosis/condition |
| | Exclusion | None |
| 3 | Abbreviated Name | Suicide of an in-patient |
| | Indicator | Number of reported incidents where suicide of an inpatient occurred in a health establishment |
| | Numerator | Number of reported incidents where suicide of an inpatient occurred |
| | Denominator | None |
| | Regulation | 17(1) The Health establishment must have systems to protect users, health care personnel and property from security threats and risks |
| | Short definition | The act of intentionally causing one's own death whilst in an in-patient unit |
| | Reporting requirement | Reported within 24 hours of the health establishment becoming aware of the incident |
| | Indicator type | Incident report |
| | Applicability | Health establishments with admission facilities |
| | Inclusion | All patient who commit suicide whilst admitted irrespective of the diagnosis/condition |
| | Exclusion | None |
| 4 | Abbreviated Name | Unavailability of Radiological services |
| | Indicator | Number of reported incidents where radiological services were not available in a health establishment |

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| | Numerator | Number of reported incidents where radiological services were not available |
| | Denominator | None |
| | Regulation | 11(1) The health establishments must ensure that diagnostic services are available and safe for users and for health care personnel involved in delivering these services 19(2)(a) The health establishment must, as appropriate to the size and type of health establishment have and implement a human resource plan that meet the needs of the health establishment |
| | Short definition | Radiological services cannot be rendered due to unavailability of equipment (CT-scan, X-ray and sonar service) or staff for a period exceeding 3 hours. |
| | Reporting requirement | To be reported when radiological services are not available for a period exceeding 3 hours |
| | Indicator type | Incident report |
| | Applicability | Health establishments with CT-Scan, X-ray and sonar services |
| | Inclusion | 1.X-rays, CT-Scans, Sonar that are non-functional resulting in lack of service delivery 2. Staff not available to render the services |
| | Exclusion | 1.Health establishment able to replace/rent the equipment within 3 hours 2. Planned maintenance of equipment and contingency in place for services to be rendered |
| 5 | Abbreviated Name | Unavailability of hand washing soap |
| | Indicator | Number of reported incidents where hand washing soap was not available in a health establishment |
| | Numerator | Number of reported incidents where hand washing soap was not available |
| | Denominator | None |
| | Regulation | 8(2)(a) A health establishment must ensure that there are hand washing facilities in every service area |
| | Short definition | Part of or whole health establishment not having antimicrobial hand washing soap at the point of care |
| | Reporting requirement | To be reported within 24 hours of the health establishment becoming aware of the unavailability soap in part of or the whole HE. The indicator is to be reported daily until it has been remedied. |
| | Indicator type | Incident report |
| | Applicability | All health establishments |
| | Inclusion | Health establishment without hand washing soap and contingency not in place |
| | Exclusion | Use of antiseptics as a contingency |
| 6 | Abbreviated Name | Acts of harm to staff |
| | Indicator | Number of reported incidents where acts of harm or threats to staff occurred in a health establishment |
| | Numerator | Number of reported incidents where acts of harm or threats to staff occurred |
| | Denominator | None |
| | Regulation | 17(1) The Health establishment must have systems to protect users, health care personnel and property from security threats and risks |
| | Short definition | Any acts of harm or threat to staff |
| | Reporting requirement | Reported within 24 hours of the health establishment becoming aware of the incident |
| | Indicator type | Incident report |

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| | Applicability | All health establishments |
| | Inclusion | All acts of harm or threats to staff irrespective of the degree of harm |
| | Exclusion | None |
| 7 | Abbreviated Name | Acts of harm to patients |
| | Indicator | Number of reported incidents where acts of harm or threats to patients occurred in a health establishment |
| | Numerator | Number of reported incidents where acts of harm or threats to patients occurred |
| | Denominator | None |
| | Regulation | 17(1) The Health establishment must have systems to protect users, health care personnel and property from security threats and risks |
| | Short definition | Any act of harm or threats to patients |
| | Reporting requirement | Reported within 24 hours of the health establishment becoming aware of the incident |
| | Indicator type | Incident report |
| | Applicability | All health establishments |
| | Inclusion | All acts of harm or threats to patients irrespective of the degree of harm |
| | Exclusion | None |
| 8 | Indicator | Unavailability of water for > 24 hours |
| | Indicator | Number of reported incidents where no water was available for a period >24 hours in a health establishment |
| | Numerator | Number of reported incidents where no water was available for a period >24 hours |
| | Denominator | None |
| | Regulation | 15(2) A health establishment must have 24-hour electrical power, lighting, medical gas, water supply and sewerage disposal system |
| | Short definition | Part of or the whole HE does not have water in patient care areas for more than 24 hours |
| | Reporting requirement | Reported when a HEs has no water for a period exceeding 24 hours. Report daily until water is available in the health establishment. |
| | Indicator type | Incident report |
| | Applicability | All health establishments |
| | Inclusion | Health establishment without water for >24 hours with no contingency plan/back-up water supply |
| | Exclusions | Health establishment with functional back-up water supply |
| 9 | Abbreviated Name | Retained foreign object in a patient following a surgical/invasive procedure |
| | Indicator | Number of reported incidents where a foreign object was retained in a patient following an invasive procedure in a HEs |
| | Numerator | Number of reported incidents where a foreign object was retained in a patient following an invasive procedure |
| | Denominator | None |
| | Regulation | 7(2)(b) the health establishment must establish and maintain systems, structures and programmes to manage clinical risk |
| | Short definition | Retention of a foreign object in a patient following a surgical/invasive procedure. |
| | Reporting requirement | Reported within 24 hours of the health establishment becoming aware of the incident |
| | Indicator type | Incident reporting |
| | Applicability | Health establishments that conduct surgical procedures |
| | Inclusion | 1. including retention of conception products 2. interventions performed outside the surgical environment e.g. central line insertion |
| | exclusion | Where items are subject to the counting/checking process are inserted during the procedure and then intentionally retained after its |

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| | | completion, with removal planned for a later time or date as clearly recorded in the patient's notes |
| 10 | Abbreviated Name | Wrong site surgery |
| | Indicator | Number of reported incidents where an invasive procedure was performed on a wrong site, a wrong procedure performed, or procedure performed on a wrong patient in a HEs |
| | Numerator | Number of reported incidents where an invasive procedure was performed on a wrong site, wrong procedure or wrong patient |
| | Denominator | None |
| | Regulation | 7(2)(b) the health establishment must establish and maintain systems, structures and programmes to manage clinical risk |
| | Short definition | An invasive procedure performed on the wrong patient, or at the wrong site (e.g. wrong knee, eye, limb, tooth) or a wrong procedure. The incident is detected at any time after the start of the procedure. |
| | Reporting requirement | Reported within 24 hours of the health establishment becoming aware of the incident |
| | Indicator type | Incident report |
| | Applicability | Health establishments that conduct surgical procedures |
| | Inclusion | Interventions that are considered to be surgical but may be done outside a surgical environment – for example, wrong site block (including blocks for pain relief), biopsy, interventional radiology procedure, cardiology procedure, drain insertion and line insertion (eg peripherally inserted central catheter (PICC)/ Hickman lines). This also includes teeth extracted in error that are immediately replanted. |
| | Exclusion | Interventions where the wrong site is selected because the patient has unknown/unexpected anatomical abnormalities; these should be documented in the patient's notes |
| 11 | Abbreviated Name | Procedure-related avoidable deaths |
| | Indicator | Number of procedure related deaths that were reported in a HEs |
| | Numerator | Number of procedure related deaths that were reported |
| | Denominator | None |
| | Regulation | 7(2)(b) the health establishment must establish and maintain systems, structures and programmes to manage clinical risk |
| | Short definition | Any death (avoidable) of a patient that occurs following a surgical(invasive) procedure |
| | Reporting requirement | Reported within 24 hours of the health establishment becoming aware of the incident. |
| | Indicator report | Incident report |
| | Applicability | Health establishments that conduct surgical procedures |
| | Inclusion | Avoidable procedure related deaths according to the Mortality and Morbidity meeting outcome/ health establishment's investigation/analysis Emergency Caesarean section |
| | exclusion | Emergency procedures |