

# INCIDENTS

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Understanding the concepts underlying patient safety incidents is useful because it helps to anticipate situations that are likely to lead to errors and highlights areas where preventative action can be taken. The problem of error can be viewed in two ways – from a person approach or from a system approach.

Human factors  
Inadequate patient assessment; delays or errors in diagnosis  
Failure to use or interpret appropriate tests  
Error in performance of an operation, treatment or test  
Inadequate monitoring or follow-up of treatment  
Deficiencies in training or experience  
Fatigue, overwork, time pressures  
Personal or psychological factors (e.g. depression or drug abuse)  
Patient or working environment variation  
Lack of recognition of the dangers of medical errors  
System failures  
Poor communication between healthcare providers  
Inadequate staffing levels  
Disconnected reporting systems or over-reliance on automated systems  
Lack of coordination at handovers  
Drug similarities  
Environment design, infrastructure  
Equipment failure owing to lack of parts or skilled operators  
Cost-cutting measures by hospitals  
Poor governance structures and inadequate systems to report and review patient safety incidents  
Medical complexity  
Advanced and new technologies  
Potent drugs, their side effects and interactions  
Working environments – intensive care, operating theatres

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Revision #1

Created 2025-12-31 15:09:30 UTC by Omar Ayman

Updated 2025-12-31 15:09:30 UTC by Omar Ayman