

## GYNAECOLOGY TRIGGER LIST

CLINICAL INCIDENT	ORGANISATIONAL INCIDENT
<ul style="list-style-type: none"> <li>• Vasovagal attack following outpatient procedure/examination which required medical intervention</li> <li>• Delayed or missed diagnosis (e.g. ectopic pregnancy)</li> <li>• Any MRSA on Gynaecology Ward/Gynaecology Patient</li> <li>• Anaesthetic complications</li> <li>• Procedure performed without consent /not in the patient's best interest</li> <li>• Omission of planned procedures (e.g. failure to insert a planned intrauterine contraceptive device after a hysteroscopy)</li> <li>• Failed procedure (e.g. abortion, sterilization)</li> <li>• Change of access during operation due to unexpected complications (e.g. Laparoscopic/vagina – open or Transverse – Midline)</li> <li>• Damage to structures (e.g. bladder, ureter, bowel, blood vessel)</li> <li>• Complications relating to recognised/unrecognised injury presenting later (e.g. fistula)</li> <li>• Unexpected operative blood loss &gt; 1000ml ml</li> <li>• Blood transfusion (not anticipated by pre-op Hb)</li> <li>• Unplanned intensive care admission</li> <li>• Wound complications requiring readmission</li> <li>• Unplanned return to theatre</li> <li>• Hospital acquired venous thromboembolism</li> <li>• Critical/severe ovarian hyperstimulation (assisted conception)</li> <li>• Unplanned readmission to hospital within 30 days following a procedure</li> <li>• Retained swab/instrument</li> </ul>	<ul style="list-style-type: none"> <li>• Clinic over-run by &gt;90 mins</li> <li>• Missing/mixed up investigation results</li> <li>• Delay following call for assistance</li> <li>• Faulty equipment</li> <li>• Conflict over case management</li> <li>• Potential service user complaint</li> <li>• Medication error</li> <li>• Marked deviation from local guideline</li> <li>• Overnight stay on trolley in EGAU</li> <li>• Transfer of patients across sites</li> </ul> <p><u>Trust policy</u></p> <p><b>Unplanned return to theatre</b></p> <p><b>Unplanned readmission</b></p> <p><b>Prolonged episode of care</b></p> <p><b>Extra time in hospital or as an inpatient</b></p> <p><b>Cancelling of treatment</b></p> <p><b>Unplanned ITU admission</b></p> <p><u>Harm Event due to Backlog</u></p> <p><b>Low Harm</b> – prolonged symptoms e.g. wait for OPA&gt;18weeks; delay to P1 surgery</p> <p><b>Moderate Harm</b> – increase in symptoms, medication or treatment e.g. pt attending EGAU while on OPWL or IPWL; A&amp;G request to expedite treatment</p> <p><b>Severe Harm</b> – irreversible disease progression, death on waiting list, delayed diagnosis or progression of cancer e.g. pt&gt;39yrs waiting &gt;6months for fertility treatment</p>

This is *not* exhaustive

Any event which is *not a normal consequence* of care please report Jan 2026

# Incident Reporting

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### Key amendments to this Document:

Date	Amendment	By:
29 <sup>th</sup> December 2023	Document extended for 6 months whilst under review to 29 <sup>th</sup> June 2024	Alex Blackwell
20 <sup>th</sup> August 2024	Document extended for 6 months whilst under review to 20 <sup>th</sup> February 2024	Alex Blackwell
9 <sup>th</sup> January 2026	Document approved at Gynaecology Governance	Gynaecology Governance Meeting