Critical Patient Safety Incident Reporting and Investigation			
Signing Authority:	Chief of Staff		
Approval Date:	03-11-2014	Effective Date:	DD-MM-YYYY

SCOPE:

This policy and procedure applies to all employees of the Royal Victoria Regional Health Centre (RVH) as well as professional staff with RVH privileges (i.e., medical, dental, midwifery, and extended class nurses), volunteers, students, and contractors. These individuals shall be referred to collectively as *workers* herein. The requirements apply whether working on RVH property or working on behalf of or representing RVH elsewhere.

POLICY STATEMENT:

It is the policy of RVH to report and investigate all patient safety incidents in order to promote a culture of safety and to create learning opportunities for quality improvement. This document outlines the actions required when a critical patient safety incident occurs at RVH.

DEFINITIONS:

Critical Patient Safety Incident: Any unintentional event that occurs when a patient receives treatment in the hospital;

a) that results in death, or serious disability, injury or harm to the patient, and
b) that does not result primarily from the patient's underlying medical condition or from a known risk inherent in providing treatment.

Examples of critical patient safety incidents include but are not limited to:

- Any patient death, paralysis, coma or other major loss of function associated with an adverse drug event or adverse transfusion reaction.
- Any fracture resulting from an incident occurring within the organization.
- Surgically related incidents such as wrong side surgery, wrong patient being operated on or wrong procedure being performed.
- Equipment malfunction, unavailability, disconnection or failure that resulted in loss or potential loss of life, limb or function to a patient.
- Unexpected deaths, including suicides or attempted suicides within the organization.
- Patient outcome is symptomatic, requiring life-saving intervention or major surgical/medical intervention, shortening life expectancy or causing major permanent or long term harm or loss of function.

Harm: An outcome that negatively affects a patient's health and/or quality of life.

Initial Understanding of Facts: Within the first four hours of a critical patient safety incident or near miss critical patient safety incident, the program Manager or the Hospital Service Leader (HSL) shall assemble an initial understanding of facts. This initial understanding of facts shall be documented in the Safety Learning System and shall include:

- Location of patient safety incident
- Patient identifiers (i.e., patient name and V#)
- Workers involved in incident
- Brief factual description of incident
- Initial interview of patient and workers involved

National System for Incident Reporting (NSIR): A database through Canadian Institute for Health Information designed to capture a subset (i.e., intravenous medications or fluids) of all critical patient safety incident reporting.

- It should be noted that per the *Excellent Care for all Act*, when Critical Patient Safety Incidents are linked to medications or intravenous fluids, hospitals are required to submit the incident details to the NSIR within 30 days following disclosure of the incident to the Medical Advisory Committee (MAC). The information shall be submitted by Patient Safety, Quality and Risk Management (PSQRM).

Quality of Care Committee (QCC): A group of stakeholders governed by the provisions of the *Quality of Care Information and Protection Act (QCIPA)* who review matters that may give rise to significant quality of care concerns including, but not limited to:

- A patient safety incident involving unexpected death or serious bodily harm
- A patient safety incident or series of incidents that have the potential to result in death or serious bodily harm
- A patient safety incident or series of incidents that have the potential to result in harm to a number of patients

Safety Learning System (SLS): The electronic incident management system adopted by RVH to capture all patient and worker incidents. Specific roles assigned within the SLS **reviewer**, the person who is responsible for the management of the incident within the SLS, and **investigator(s)**, the person or people invited by the person initiating the incident to participate in the review and document on a specific incident.

PROCEDURE:

(Refer to *Appendix I: Critical Patient Safety Incident Checklist and Appendix II: Critical Patient Safety Incident Reporting and Investigation Procedure Algorithm)*

Person discovering critical patient safety incident

1. Immediately provide appropriate patient care and implement corrective actions to prevent harm to the patient or anyone else. If required, seek assistance from Resource/Charge Nurse, physician and interprofessional team. If required, contact Security Services to secure the scene and/or preserve evidence.
2. Verbally report critical patient safety incident to appropriate leader:
   - Resource Nurse/Charge Nurse/Team Leader/Supervisor
   - Unit Manager/Hospital Service Leader (HSL)
   - Attending/most responsible Physician
   - Pharmacist, when applicable
3. Disclose critical patient safety incident to the patient and/or patient's substitute decision maker (SDM) following the Disclosure of Harm Policy 1.053.
4. Utilize the Critical Patient Safety Incident Review Checklist to obtain the Initial Understanding of the Facts (please refer to Appendix I).
5. Document facts of critical patient safety incident in progress notes, physician's progress notes, and other clinical forms as appropriate.
6. Enter critical patient safety incident in the SLS.

<u>Unit Manager/HSL or delegate</u>

1. Acknowledge receipt of critical patient safety incident within four hours in SLS by changing Approval Status to "Being Reviewed."
2. Immediately notify:
   - Program Operations Director, Most Responsible Physician (MRP), Vice President (VP) on call, and Chief of Staff within four hours.
   - Director of PSQRM within 24 hours**.**
3. Where a critical patient safety incident resulted from a physical hazard on RVH premises (e.g., slippery or uneven surface, etc.) to which workers are also vulnerable, please refer to Occupational Health and Safety policy 11.5, *Critical Injury and Fatality Reporting and Investigation*.
4. Initiate review within the SLS.
   a) Identify if you are the appropriate reviewer. Re-assign reviewer if required.
   b) Assign other investigators to the critical patient safety incident as required.
   c) Interview appropriate workers and document any recommended follow-up actions.
   d) Once the critical patient safety incident review is complete, engage appropriate stakeholders to implement any applicable recommendations.
5. Complete all documentation in the SLS, enter "Closed Date" and change Approval Status to "Final Approval" within 18 days.

<u>Operations Director/Director</u>

1. Immediately notify the appropriate VP and Director of PSQRM within 24 hours.
2. Ensure appropriate follow up has occurred including physician and appropriate

physician leadership.
3. Lead and or/participate in case review.

Director of PSQRM

Within 48 hours of critical patient safety incident (during regular business hours):

1. Notify the Executive Vice President (EVP), Chief Nursing Officer (CNO) and Chief of Staff within 48 hours.
2. Consult with the EVP, Chief of Staff and Chair of the Medical Advisory Committee (MAC) to determine if incident review shall be conducted under *QCIPA.*
3. Prepare a communication plan if necessary.
4. Work with Manager and Operations Director to complete case review for purpose of identifying systemic quality improvement opportunities.
5. Support the follow through with the RVH Disclosure of Harm Policy 1.053.
6. Work with the EVP, Chief of Staff and Chair of MAC to ensure the critical patient safety incident is appropriately reported to the Administrator and MAC.
7. Refer to the process within the Quality of Care Committee terms of reference.

Downtime Procedure

In the event the Safety Learning System becomes unavailable, paper-based forms are available throughout the facility within the downtime binder on each unit. Once complete, the form shall be provided to immediate supervisor. The supervisor shall proceed with their normal follow-up process and forward a photocopy of the signed form to the PSQRM office within 10 days.

CROSS REFERENCES:

Administrative Policy and Procedure 1.053 *Disclosure of Harm* (2014).
Administrative Policy and Procedure 1.045 *Coroner's Case Protocol* (2014).
Occupational Health and Safety policy 11.5, *Critical Injury and Fatality Reporting and Investigation* (2014).

REFERENCES:

Canadian Incident Analysis Framework. (2012) Canadian Patient Safety Institute
Davies, J.M., Hebert, P., Hoffman, C. (October 2003). *Canadian Patient Safety Dictionary*.
Excellent Care for All Act (2010, 2011)
Public Hospitals Act R.R.O. 2010 Regulation 965
Quality of Care Information and Protection Act (2004)
Royal College of Physicians and Surgeons of Canada. (2003).
World Health Organization. (2009). WHO Patient Safety Research: Patient Safety A World Alliance for Safer Healthca

Critical Patient Safety Incident Reporting and Investigation Checklist: Appendix I

Purpose: This checklist serves to support all workers and to ensure all appropriate steps are being followed when initially reviewing critical patient safety incidents.

All Workers

- ☐ Refer to the Patient Safety Incident Policy 1.095 and the Critical Patient Safety Incident policy 1.096
- ☐ Secure and treat patient immediately
- ☐ Ensure patients and staff are safe and put immediate safeguards in place so incident does not reoccur
- ☐ Report verbally to
    - Resource nurse
    - Unit Manager
    - Hospital Service Leader
    - Most responsible physician
- ☐ Document patient safety incident facts in progress notes
- ☐ Enter incident into Safety Learning System (SLS)
- ☐ Be prepared to supply manager and director with facts of incident
- ☐ Disclose incident to patient if appropriate. Refer to Disclosure policy 1.053.

Resource Nurse/ Charge Nurse

- ☐ Immediately ensure safety of patient and staff
- ☐ If not already complete, report verbally to:
    - Unit Manager
    - Hospital Service Leader
    - Most responsible physician
- ☐ Ensure documentation is complete in patient file and incident is entered into SLS
- ☐ Disclose incident to patient if appropriate. Refer to Disclosure policy 1.053 on Intranet under administrative policies

Manager/HSL

- ☐ Immediately ensure safety of patient and staff
- ☐ Verbally report incident to Operational Director
- ☐ If after hours, report incident to MRP, VP on call and Chief of Staff.
- ☐ Within 4 hours, perform initial review with staff and initiate incident documentation in SLS
- ☐ Initial review contains;
    - Location of incident (patient room, hallway, OR, etc)
    - Patient identifiers V# and name
    - Staff members involved in incident
    - Brief Factual Description of Incident
    - Interviews of patient and staff members involved
- ☐ As long as incident is entered into SLS as critical incident, automatic email shall be sent to the Director of the program and the Patient Safety, Quality and Risk Management team
- ☐ Patient Safety, Quality and Risk Management shall contact Manager of department within 24 hours to begin plan for further review

Operational Director

- ☐ Ensure Director of Patient Safety Quality and Risk Management has received SLS notification.
- ☐ Notify appropriate VP
- ☐

Critical Patient Safety Incident Reporting and Investigation Algorithm: Appendix II