



## **A Primer on Patient Safety Events** **Winnipeg Regional Health Authority** **October 2013**

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**Each Patient Safety Event listed below includes a definition, procedures for reporting, information about what happens after the event is reported, and the status of the policy related to the event.**

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## **Critical Incident (CI)**

### Policy and Procedures

The WRHA policy titled *Critical Incident Management and Learning* (10.50.040) addresses Critical Incidents and how to report them. The policy is in the process of being revised. The policy fulfills the responsibilities as outlined in the Regional Health Authorities Amendment Act, the Manitoba Evidence Amendment Act and the Manitoba Health policy pertaining to Critical Incidents and disclosure of Critical Incidents.

### Definition

A Critical Incident is an unintended event that occurs when health services are provided to an individual and results in a consequence to him or her that:

- is serious and undesired, such as death, disability, injury or harm, unplanned admission to hospital, or unusual extension of a hospital stay, and;
- does not result from the individual's underlying health condition or from a risk inherent in providing the health services.

### Reporting a Critical Incident

Staff with access to RL6: Risk may report a Critical Incident through RL.

Anyone may report a Critical Incident by calling the WRHA Critical Incident Reporting and Support Line (CIRSL), 24 hours a day, 7 days a week at 788-8222. Callers who choose to may report anonymously.

### What happens after I report a Critical Incident?

- By law, a facility, program or area representative will ensure that appropriate disclosure to the patient and/or family members occurs.
- An individual will be designated to provide ongoing contact and support for the patient and family members as appropriate
- A Critical Incident Review Committee (CIRC) is named to review the Critical Incident and make recommendations as appropriate, in concert with the site/program leadership.
- A written report of the CIRC review is provided to the senior leader of the facility, program or area, as well as to Manitoba Health.

For more information about Critical Incidents see the WRHA website at <http://www.wrha.mb.ca/healthinfo/patientsafety/criticalincident/index.php>.

## **Critical Occurrence (CO)**

### Policy and Procedures

In September 2012, Manitoba Health approved a new *Critical Occurrence (CO) Management and Reporting Policy*. The WRHA policy titled *Occurrence Reporting and Management (10.50.020)* addresses Critical Occurrences and how to report them. However, the WRHA is in the process of revising its policy to include Occurrences, Critical Occurrences and Near Misses.

### Definition

A Critical Occurrence (CO) is an event that does not directly involve patients, but involves one or more of the following:

- serious harm to employees, medical staff, volunteers, students, visitors, and other persons associated with the facility or service
- the potential to negatively affect public confidence, credibility and trust, including potential media involvement or litigation
- unplanned or unexpected disruptions to the delivery of services and programs
- an emergency or disaster
- a significant public health event

### Reporting a Critical Occurrence

Staff should report a Critical Occurrence directly to their manager, who in turn reports the CO immediately to their Director. Directors immediately report the CO to their WRHA Vice President (VP) and to the WRHA CO Mailbox at **Critical Occurrences Mailbox** found in Outlook. Outside of regular office hours the Administrator on Call should be notified immediately of a Critical Occurrence.

When reporting a Critical Occurrence you need to include the following information:

- Name of the Regional Health Authority
- Time and date of the CO
- Brief description of the facts and the condition of individuals, facilities and/or programs involved
- Steps taken to mitigate further harm, if appropriate
- The reporting person's name and contact information

### What happens after I report a Critical Occurrence?

- Within 2 business days, a decision is made regarding the type of review required for the CO.
- Within 30 days the WRHA must submit a report on the CO to Manitoba Health.
- Reports need to contain the name of the Regional Health Authority, the date and time of the CO, and any findings, recommendations and follow-up action plans related to the CO.

Description of Critical Occurrence	Examples
Any occurrence involving serious harm to employees, medical staff, volunteers, students, visitors, and other persons associated with the facility/community service, or to property, reputation or security.	<ul style="list-style-type: none"> <li>• Suicide, or other unexpected death or serious injury of an employee while on the job</li> <li>• Emergency Medical Services (EMS) motor vehicle collision</li> <li>• Serious verbal, physical, psychological or sexual abuse involving any of the groups noted at the left</li> </ul>
Any occurrence that has the likelihood to negatively affect public confidence, credibility and trust, including potential media involvement or litigation.	
Any occurrence involving an unplanned or unexpected disruption in the delivery of health care programs or services which may result in increased risk to patients/clients/residents (excludes planned and mitigated service reductions).	<ul style="list-style-type: none"> <li>• Service withdrawal or disruption where access is decreased such as a water main break or gas leak causing closure of beds, evacuation of patients/residents etc.</li> <li>• Equipment or system breakdown which has a significant impact on patients</li> <li>• Unexpected employee absence that significantly affects operations (due to illness, abandonment of post etc.)</li> <li>• Supply chain issues which may result in decreased availability of supplies and/or medications such that services may need to be changed, interrupted or curtailed in some way</li> <li>• Natural disasters (e.g. fires, floods, severe weather, etc.)</li> <li>• Human caused events (e.g. hazardous materials accidents, terrorism, bomb threats etc.)</li> <li>• Technological events (e.g. telecommunications failure, power outage, water/sewer failure etc.)</li> </ul>
A significant public health event having one or more the characteristics listed on the right:	<ul style="list-style-type: none"> <li>• Outbreaks of infectious diseases that affect the delivery of health services and programs</li> <li>• Contamination of food or water supply that affect the delivery of health services and programs</li> <li>• Events that have caused or have the potential to cause morbidity and mortality</li> <li>• Events that have significant implications for another region and/or jurisdiction (e.g. an outbreak extending beyond borders of an RHA, a new situation that has not been dealt with before.)</li> <li>• Events likely to create media interest</li> </ul>

## **Near Miss**

### Policy and Procedures

The WRHA currently does not have a policy or formal procedure for Near Misses. Near Misses will be included in the revised Occurrence policy which is under development.

### Definition

A Near Miss is an event which did not reach the patient. An example could be a nurse almost administering the wrong medication, but noticing this potential event prior to administering the drug.

### Reporting a Near Miss

A Near Miss event is reported through RL6: Risk.

### What happens after I report a Near Miss?

- Managers and Directors are required to review the event in RL and complete any follow-up required and document actions taken.
- Upon request, provide feedback to the individual who reported the event in collaboration with others involved in the event, as appropriate. Feedback may include actions taken following the Near Miss, review results and/or follow-up action plans.

**Did you know....**if an event involves employee work-related injury/illness or violence/aggression/abuse you need to complete an Injury/Near Miss form available through the WRHA Occupational & Environmental Health & Safety department. A Near Miss that relates to a Staff Incident (vs. a patient) is also reported on the Injury/Near Miss form.

An Occurrence report is not required for events involving staff injury or staff Near Misses.

## Occurrence

### Policy and Procedures

The WRHA policy titled *Occurrence Reporting and Management* (10.50.020) addresses Occurrences and how to report them. The policy is in the process of being revised.

### Definition

An Occurrence is a patient-related event or circumstance that resulted in an unintended and undesired outcome such as an injury to a patient and/or damage to or loss of equipment or property.

### Reporting an Occurrence

Occurrences are reported in RL6: Risk.

### What happens after I report an Occurrence?

- Managers and Directors are required to review the event in RL and complete any follow-up required and document actions taken.
- Upon request, provide feedback to the individual who reported the event in collaboration with others involved in the event, as appropriate. Feedback may include actions taken following the Occurrence, review results and/or follow-up action plans.

**Did you know...**if an event involves employee work-related injury/illness or violence/aggression/abuse you need to complete an Injury/Near Miss form available through the WRHA Occupational & Environmental Health & Safety department. A Near Miss that relates to a Staff Incident (vs. a patient) is also reported on the Injury/Near Miss form.

An Occurrence report is not required for events involving staff injury or staff Near Misses.

## Levels of Harm Definitions

<b>Level of Harm</b>	<b>Definition</b>	<b>Type of Patient Safety Event likely to fit within the Level of Harm</b>
None	The Patient outcome is not symptomatic or no symptoms detected and no treatment is required. Also, can include the event being “caught” before it adversely impacts a patient.	Occurrence or Near Miss
Minimal	The patient outcome is symptomatic, symptoms are mild, loss of function or harm is minimal or intermediate but short term, and no or minimal intervention (e.g. extra observation, investigation, review or minor treatment) is required.	Occurrence
Moderate	The patient outcome is symptomatic, requiring intervention (e.g. additional operative procedure; additional therapeutic treatment), an increased length of stay, or causing permanent or long term harm or loss of function.	Occurrence or possibly a Critical Incident depending on whether the event meets the legal definition of a CI
Severe	The 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.	Most likely a Critical Incident but could be an Occurrence (depending on the specific event)
Death	On the balance of probabilities, death was caused or brought forward in the short term by the event.	Could be a Critical Incident or an Occurrence. Again, it depends on whether the event meets the legal definition of a CI