Winnipeg Regional Health Authority
Caring for Health

Office régional de la santé de Winnipeg
À l'écoute de notre santé

A Primer on Patient Safety Events
Winnipeg Regional Health Authority
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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.

Critical Incident (CI)

Policy and Procedures

The WRHA policy titled *Critical Incident Reporting and Management* (10.50.040) addresses Critical Incidents and how to report them. 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.

Examples of Critical Incidents

- A wrong-side surgery
- A wrong medication administered causing death
- A stage 3, 4 or unstageable pressure ulcer

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 *Critical Occurrence Reporting and Management* (10.50.045) addresses Critical Occurrences and how to report them.

Definition

A Critical Occurrence is an event within the Winnipeg-Churchill health region, (excluding those such as Critical Incidents #10.50.040 and Occurrences #10.50.045) that result in one or more of the following:

- Serious harm to Staff, visitors and other persons associated with the facility;
- The potential to significantly and negatively affect public confidence, credibility and trust;
- Significant and prolonged disruptions to the delivery of service and programs, when the disruptions are unplanned or unexpected;
- An emergency or Disaster, or;
- A Significant Event Affecting the Health of the Public.

Examples of Critical Occurrences

- A fire causing mass evacuation of patients/residents
- A flood causing power and heat outages, resulting in loss of healthcare services and/or mass evacuation of patients/residents

Reporting a Critical Occurrence

During regular business hours, Critical Occurrences are reported immediately to an immediate supervisor or designate who will report to the Site Critical Occurrence designate. If the Critical Occurrence occurs after hours the Critical Occurrence will be reported to the Site Administrator on Call. When reporting a Critical Occurrence you need to include the following information:

- name of the site;
- time and date of the Critical Occurrence;
- brief description of the facts of what occurred and the condition of the staff and site;
- steps taken to mitigate harm, and;
- the reporter's name, phone number and e-mail address.

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.	• Suicide, or other unexpected death or serious injury of an employee while on the job • Emergency Medical Services (EMS) motor vehicle collision • Serious verbal, physical, psychological or sexual abuse involving any of the groups noted at the left
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).	• 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. • Equipment or system breakdown which has a significant impact on patients • Unexpected employee absence that significantly affects operations (due to illness, abandonment of post etc.) • 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 • Natural disasters (e.g. fires, floods, severe weather, etc.) • Human caused events (e.g. hazardous materials accidents, terrorism, bomb threats etc.) • Technological events (e.g. telecommunications failure, power outage, water/sewer failure etc.)
A significant public health event having one or more the characteristics listed on the right:	• Outbreaks of infectious diseases that affect the delivery of health services and programs • Contamination of food or water supply that affect the delivery of health services and programs • Events that have caused or have the potential to cause morbidity and mortality • 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.) • Events likely to create media interest

Near Miss/Good Catch

Policy and Procedures

The WRHA policy titled *Occurrence, Near Miss Reporting and Management* (10.50.020) addresses Near Misses/Good Catches and how to report them.

Definition

A Near Miss/Good Catch is an event or situation that took place, and could have resulted in an unintended outcome, but was "caught" before adversely impacting the Patient. An example could be a nurse almost administering the wrong medication, but noticing this potential event prior to administering the drug.

Examples of Near Miss

- Almost administering the wrong medication but "catching it" before this happens
- "Catching" that you are about to administer a medication to the wrong patient/resident

Reporting a Near Miss/Good Catch

A Near Miss/Good Catch event is reported through RL6: Risk.

What happens after I report a Near Miss/Good Catch?

- Managers and Directors are required to review the event in RL and complete any follow-up required and document actions taken. The process is the same as with an Occurrence.
- 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/Good Catch, review results and/or follow-up action plans.

Did you know…..A Near Miss that relates to a Staff Incident (vs. a patient) is reported on the WRHA Occupational & Environmental Health & Safety Injury/Near Miss form.

A Near Miss/Good Catch report is not required for events involving staff injury or staff Near Misses.

Occurrence

Policy and Procedures
The WRHA policy titled *Occurrence, Near Miss Reporting and Management* (10.50.020) addresses Occurrences and how to report them.

Definition
An Occurrence is an event or circumstance that resulted in an unintended and undesired outcome such as an ***injury to a Patient that did not meet the definition of a Critical Incident*** #10.50.040, and/or damage to or loss of equipment or property.

Examples of Occurrences
- Administering the wrong medication to a patient/resident but no or minimal harm was done
- A patient/resident fall that results in no or minimal harm

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

Level of Harm	Definition	Type of Patient Safety Event likely to fit within the Level of Harm
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/Good Catch
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