Types of Patient Safety Events

Near Miss

An event or situation that took place, and could have resulted in an unintended outcome, but was 'caught' before adversely impacting the Patient

Example

• The wrong opioid medication is delivered. Staff recognize the error before the client receives the first dose

Critical Incident

An unintended event that occurs when health services are provided to a patient and results in a consequence to him/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 patient's underlying health condition or from a risk inherent in providing health services

Example

• A delay in recognition of sepsis in a patient results in admission to an intensive care unit

Occurrence

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

Example

• A hemodialysis machine fails while a patient is on dialysis in hospital. Staff responds promptly and replaces the equipment

Resources

WRHA Resources

- WRHA Quality Improvement & Patient Safety Website http://home.wrha.mb.ca/quality/
- WRHA Patient Safety Event Standard Operating Procedures http://home.wrha.mb.ca/quality/SOPs.php
- WRHA Critical Incident Reporting & Management 10.50.040 Critical Incident Reporting & Management http://home.wrha.mb.ca/corp/policy/files/10.50.040.pdf
- WRHA Occurrence, Near Miss Reporting & Management Policy 10.50.020 Occurrence, Near Miss Reporting & Management http://home.wrha.mb.ca/corp/policy/files/10.50.020.pdf
- Evidence-Informed Decision Making http://www.wrha.mb.ca/osd/EIPSeries.php

Additional Resources

- Improvement Frameworks Getting Started Kit by CPSI and Safer Healthcare now http://www.patientsafetyinstitute.ca/en/toolsResources/ImprovementFramework/Pages/default.aspx
- Culture Change Toolbox BC Patient Safety & Quality Council https://bcpsqc.ca/resources/culture-improvement/
- How to Improve [PDSA]. Institute for Healthcare Improvement. http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx
- The Patient Safety Education Program http://www.patientsafetyinstitute.ca/en/education/PatientSafetyEducationProgram/PatientSafetyEducationCurriculum/Pages/default.aspx

Questions?

Contact patientsafety@wrha.mb.ca