Provincial Health Services Authority
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Category: BOARD POLICY – ADMINISTRATIVE PARAMETERS	
Title: Adverse Event and Incident Management	Reference Number: AS110
Approved by: PHSA Board of Directors	Last Approved: June 22, 2011 Last Reviewed: June 22, 2011

1. PURPOSE

To assist the Provincial Health Services Authority ("PHSA") and its employees in promptly identifying and managing the immediate needs of the patient, family member, visitor, or personnel experiencing an adverse event in a PHSA Agency/Programme.

To establish guidelines for responsibilities and actions of the care team responding to an adverse event, and to support the care team by providing information on the process and support resources.

To define the processes used in the evaluation and follow-up of an incident or adverse event.

2. POLICY

The PHSA is committed to patient safety and to ensuring that all personnel understand the process and their individual responsibility in the immediate management of an adverse event and disclosure of information.

The PHSA is committed to ensuring that all personnel understand immediate event management within the larger context of hazard, adverse event and near miss identification and reporting and ensuring that they are aware of the processes used to investigate, evaluate and respond to adverse events or incidents.

3. SCOPE

The standards of behavior set forth in the policy are intended to apply to all personnel within any of the PHSA agencies.

4. ROLES IN THE IMMEDIATE MANAGEMENT OF AN INCIDENT

All personnel associated with healthcare in the PHSA agencies are expected to exercise individual responsibility and professional accountability in responding to the immediate needs of the patient, family member, visitor, or personnel experiencing an adverse event.

RESPONSIBILITIES	
The Care Team (responding to the incident)	The manager or delegate: • Addresses immediate needs of the patient/client and family. • Isolates and secures any medication, supplies or equipment which might have contributed to the incident. • If the incident is related to equipment malfunction, marks with a “Do Not Use” sign and contacts Biomedical Engineering. • Records the clinical aspects of the incident in the patient’s/client’s health record. • Report the event in the BC Patient Safety Learning System (“PSLS”). Avoid documenting in the chart that an incident report or PSLS has been completed. • Follows the agency process for notification of: a) Director of the Department/Program b) Department Chief c) Attending Physician d) Risk Management *Note:* If the incident happens during the evening, night or weekend, the administrator-on-call in charge of the facility is notified. Telephone messages are left for Risk Management. Any PHSA agency specific policy/procedure should also be followed. • Address immediate needs of staff (e.g. Critical Incident Stress Management), other patients/clients, families, visitors or personnel. • Complete the incident reporting process according to the PHSA policy entitled: “Hazards, Injuries, Harm, Adverse Events and Near Misses: Non-punitive Reporting.”
The Attending Physician or Physician Designate	For an adverse event involving a patient: • Addresses the immediate needs of the patient and family. • Offers ongoing support and information to the patient and family. • Notifies the Department or Division Chief. • Notifies the Family Physician, if appropriate. • Notifies the Coroner if: a) There is reasonable cause to suspect that a person died by violence, undue

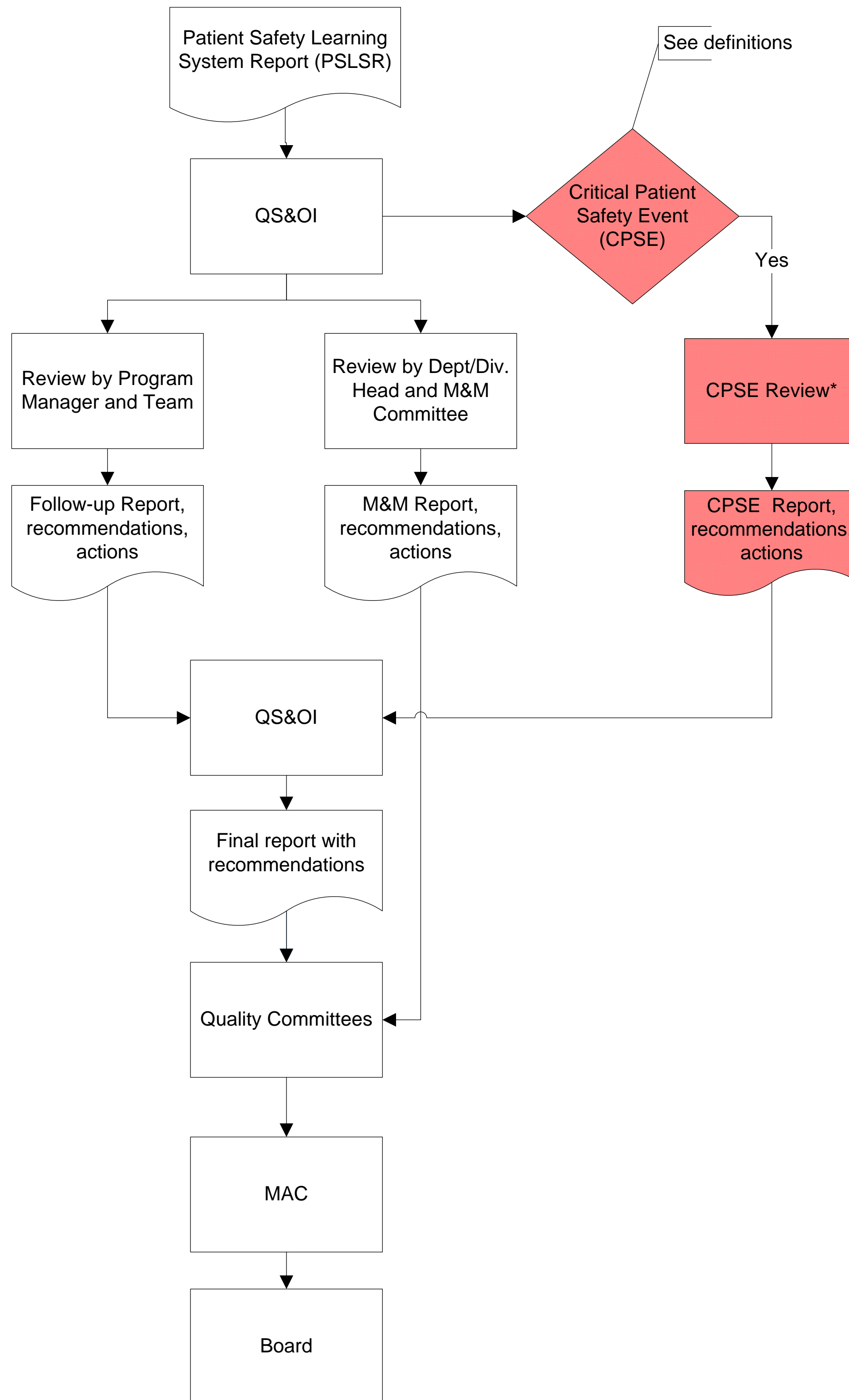
	means or culpable negligence; or b) The cause of a patient's death is undetermined. • Documents the notification to the Coroner in the health record. • Participates in the case review and the root causes analysis.
Department of Quality, Safety & Outcome Improvement	• Assists and advises on procedure for management of the incident. • Confirms notification of Agency President/Executive Director. • Defines the case review process. • May gather and secure the following (if relevant) and forwards to the Chairperson of the Case Review: a) Patient Care Record (this includes impounding the record). b) List of staff involved in care/service. c) Copies of pertinent protocols and procedures. d) Copies of relevant documentation (e.g. Kardex, medication records). e) Copies of staff rotation, assignments. f) Names of other patients, family, visitors in the room. g) Equipment, medical devices, labels etc. from the Care Team. h) Copies of any taped or written reports involving patient or incident. • Receives and compiles all reports for risk, quality and legal purposes. • Participates in the CPSER as required.
Agency President/Executive Director	Notifies Agency/PHSA Communications and PHSA President & CEO as necessary.
Communications	• Maintains accurate records of all statements, releases, newspaper articles and broadcast reports. • If deemed necessary by senior administration drafts an immediate written statement for approval by Legal Counsel and the CEO and assigns one spokesperson to respond to all media requests.

5. ACCOUNTABILITY

The PHSA will demonstrate its commitment to patient safety in the immediate time frame following an incident by establishing a policy outlining the roles and responsibilities involved in managing the incident, securing related evidence and information, and communicating incident information.

PHSA Personnel
All personnel are responsible for conducting themselves within the spirit of this policy and for contributing towards enhanced patient safety.

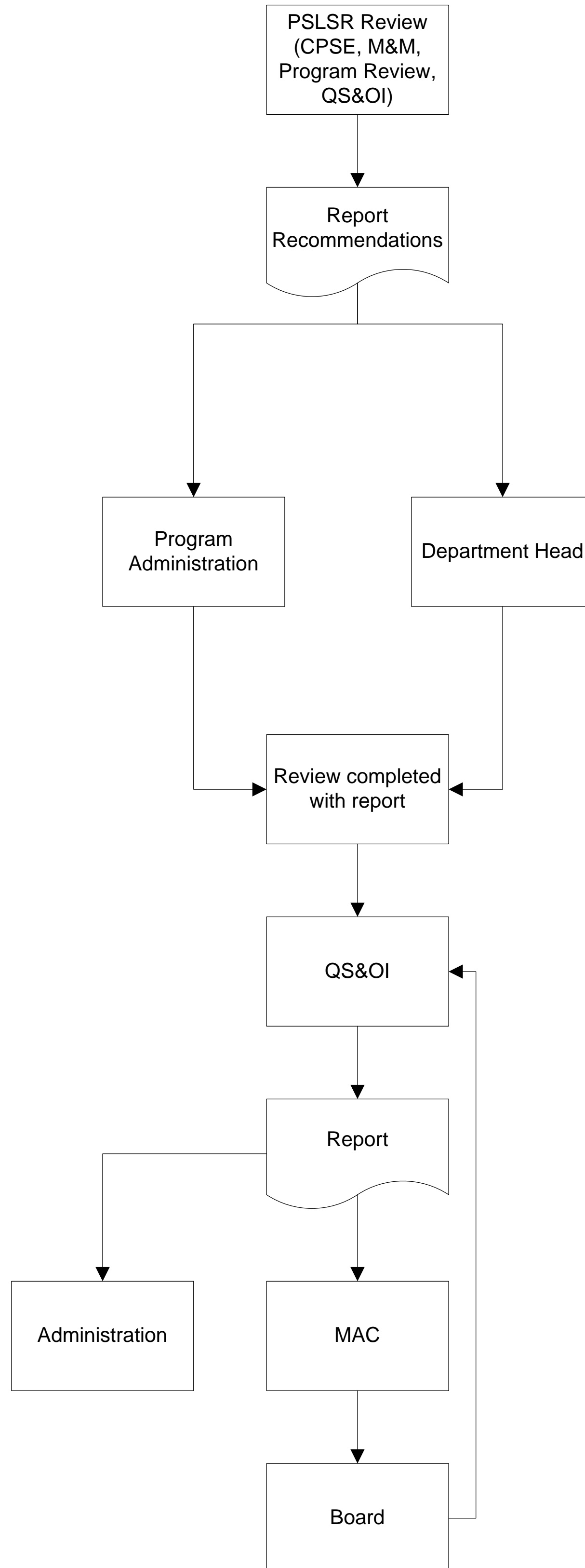
Appendix A: Patient Safety Learning Report (Incident Report) Process



Note: All PSLSRs, including those for critical incidents, are simultaneously sent for review by Program and Department/Division. A critical incident SLR is additionally reviewed through the CIR process.

* Refer to the PHSA Safety Policy: Critical Patient Safety Event Review

Appendix B: Safety Learning Report (Incident Report) Follow-Up



Appendix C: Definitions[1]

Adverse Event: A bad outcome of care. An injury that was caused by health care management rather than the patient's underlying disease, also called harm, injury, or complication. Bad outcome of care includes disability, death, prolonged hospital stay. Health care management refers to all aspects of the health care system, not just the actions or decisions of physicians or nurses.

Unpreventable adverse event: An injury (or complication) that was not due to an error or systems failure and is not always preventable at the current state of scientific knowledge. There are two major categories:

> *Type 1:* Common, well-known hazards of high-risk therapy. Patients understand the risks and accept them in order to receive the benefit of the treatment. Example: complications of chemotherapy
>
> *Type 2:* Rare but known risks of ordinary treatments. The patient may or may not have been informed of the risk in advance. Example: side-effects of medications; certain wound infections

Preventable adverse event: An injury (or complication) that results from an error or systems failure. It is useful to distinguish three categories:

> *Type 1:* Error by the attending physician. Example: technical error during performance of a procedure.
>
> *Type 2:* Error by anyone else in the healthcare team. Examples: a nurse gives wrong medication to patient; a resident makes a technical or decision error; a radiologist misses a lesion.
>
> *Type 3:* Systems failure with no individual error. Examples: IV pump failure that causes drug overdose; failure of system to communicate abnormal lab results to ordering physician.

Error: The failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. A medical error that causes harm results in an adverse event. Errors are classified as follows:

> *Serious Error:* An error that has the potential to cause permanent injury or transient but potentially life threatening harm.
>
> *Minor Error:* An error that does not cause harm or have the potential to do so.
>
> *Near Miss:* An event or error that could have caused harm but did not reach the patient because it was intercepted.

Incident: Any unexpected or undesirable event that causes harm, places a patient, visitor or staff member at risk of harm, or results in loss, damage, or theft.

Critical Patient Safety Event (CPSE): An unexpected occurrence, either immediate or latent, involving death or serious or permanent physical or psychological injury. CPSE affecting patients are by definition adverse events and may be caused by error. CPSE incidents also include

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[1] Harvard Hospitals. (2006). When things go wrong: Responding to adverse events. Massachusetts. Author.

product defects and protocol and process failures that potentially or actually result in an adverse outcome to patients, clients or the healthcare system.

Near miss: An event or error that could have caused harm but did not reach the patient because it was intercepted

Hazard: A set of circumstances of a situation that could harm a person's interests, such as their health or welfare.

Culture of Safety: An underlying philosophy of the workplace in which a shared and constant commitment to safety permeates the entire organization and is characterized by:

1) an acknowledgement of the high risk, error prone nature of PHSA's health care activities;
2) a non punitive environment where individuals are able to report incidents or near misses in order to optimize patient care outcomes;
3) the expectation of collaboration across disciplines and sectors to seek solutions to vulnerabilities; and
4) organizational willingness to direct resources to address safety concerns.

Refer to the PHSA policy entitled "Commitment to a Fair and Just Culture (Culture of Safety)".

Policy Created on: June 22, 2006
Revision Dates:
- November 2007
- June 11, 2009
- June 24, 2010