Provincial Health Services Authority
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Category: BOARD POLICY – ADMINISTRATIVE PARAMETERS	
Title: Non-Punitive Reporting: Hazards, Injuries, Harm, Adverse Events, and Near Misses	Reference Number: AS 120
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, reporting and addressing workplace hazards, injuries, harm, adverse events, and near misses in a non-punitive environment, in order to reduce opportunities for mistakes and optimize patient care outcomes.

To establish guidelines for reporting hazards, injuries, harm, adverse events and near misses using the BC Patient Safety Learning System ("PSLS") so that the PHSA can learn and improve the delivery of healthcare without harm.

To promote and maintain a just and fair working environment in which all personnel associated with healthcare in the PHSA agencies/programmes are expected to report hazards, injuries, harm, adverse events, and near misses, in order to optimize patient care outcomes. Individuals are not held accountable for system flaws over which they had no control.

To support personnel reporting harm by providing information on the process.

2. POLICY

The PHSA is committed to patient safety and to ensuring that all personnel understand their individual responsibility for reporting hazards, injuries, harm, adverse events, and near misses. The PHSA is committed to ensuring that all employees, students, fellows, physicians, and volunteers report actual or potential harm, know the process for reporting, and are aware of the expectation that these reports will be processed in a non-punitive system. The PHSA is committed to receiving patient, family, and visitor feedback regarding hazards and errors.

3. SCOPE

The standards of behavior set forth in the policy are intended to apply to all personnel within any of the PHSA agencies. While the standards of conduct apply to all personnel, the extent of the investigative procedures related to an incident under this policy may vary depending on the severity or circumstances of the event, or on the presence of professional performance issues.

4. ROLES IN THE REPORTING PROCEDURE

All personnel associated with healthcare in the PHSA agencies are expected to exercise individual responsibility in reporting hazards, injuries, harm, adverse events, and near misses, and to participate as appropriate in the analysis and resulting initiatives to improve patient safety.

RESPONSIBILITIES	
Patients and/or families	• Read the available patient safety information. • Report observed hazards and injuries, harm, adverse events to nursing, physician or administrative staff.
Direct patient care providers (e.g. physicians, nurses, pharmacists, RTs, students, residents), those working in patient care areas (e.g. housekeepers, porters, maintenance staff, delivery staff, volunteers) and those working in PHSA services with no direct patient contact (e.g. laboratory staff)	• Report hazards, all injuries, adverse events, near misses and errors using PSLS* • Participate in quality improvement activities to reduce or eliminate hazards and reduce injuries, harm, adverse events.
Managers	• Perform initial review and analysis of all incident reports using established tools and procedures**. • Forward reports to other programs or departments for further follow-up as necessary. • Provide feedback to reporters on the reporting process and review outcomes. • Collaborate with staff to identify area-specific opportunities for CQI initiatives resulting from report reviews, and participate in their implementation. • Collaborate with Quality, Safety & Outcome Improvement on the review and reporting of general trends and performance improvement strategies.
Directors	• Review initial investigation, analysis and follow-up actions to ensure appropriateness and comprehensiveness. • Identify and support quality improvement activities. • Report to administrators or senior leaders.
Administrators	• Receive information from Directors. • Ensure recommendations are implemented and corrective actions taken. • Support quality improvement initiatives.
Department of Quality, Safety & Outcome Improvement	• Receive and ensure completion of all adverse event and hazard reports and follow-up records. • Confirm notification of Agency Presidents/Executive Directors of critical patient safety events (CPSE). • Maintain database to facilitate trending and reporting. • Identify trends across populations and across programs. • Link with other departments and programs regarding indicator data for trending, reporting, and improving outcomes. • Communicate trend information by providing reports to programs, departments, and administrators. • Support and educate managers in event follow-up and analysis. • Support and facilitate CQI activities.

	• Establish structured processes for incident review, including critical patient safety event review and analysis. • Work with the programs to manage and review critical patient safety events. • Work with the agencies' insurers to address liability issues arising from events. • Report to the Quality & Access Committee of the Board on a regular basis regarding critical patient safety events, investigation and implementation of actions.
Committees	• **Department or Program Morbidity and Mortality review committees:** Review all injuries, harm, adverse events and errors occurring in patients served by the Department members and the Program: Recommend preventability class for individual adverse events. Develop recommendations for mitigation and avoidance of preventable adverse events and errors. Forward the recommendations to CPSE review committees, when applicable, and to the appropriate Safety and Quality of Medical Care committee(s). • **Critical Patient Safety Event Review Committees:**, either standing or ad hoc, review CPSE at the request of Safety and Quality of Medical Care committee chairs or their delegates, Agency/Programme or PHSA President or Board, using established processes and formats, and formulate recommendations for improvement. CPSE review committees report through the Safety and Quality of Medical Care committee to the MAC and/or directly to the Board. • **Safety and Quality of Medical Care Committees**: receive summary reports from Quality, Safety & Outcome Improvement; Critical Incident Reports from CIR Committees; and reports from Program leaders. Based on the review/report recommendations, they propose, lead and facilitate specific activities to enhance patient safety. • **Medical Advisory Committee**: receives reports from Safety and Quality of Medical Care, endorses recommendations, supports initiatives aimed at promoting patient safety, and reports to the Quality and Access Committee on these issues when necessary.
Board of Directors	• Receives governing committee and MAC reports and updates addressing all preventable injuries, harm, adverse events, serious errors and selected non-preventable adverse events and near misses through the Quality & Access Committee.

* Descriptions assume that the situation has been stabilized and the patient/family/visitor's immediate needs have been met as indicated in the PHSA policy entitled "Event and Incident Management".

** All exploratory interviews should be conducted in a respectful fashion reflecting the PHSA fair and just culture, and include opportunities for the interviewee to provide insights and suggestions for system improvement. Incident reports are never to be included as part of an employee file or health record document.

Although all factors associated with an adverse event must be explored within a systems context, individual responsibility may be assessed by the manager/Department Head during the initial review. Refer to the PHSA policy entitled: "Commitment to a Culture of Patient Safety". Investigation through separate professional performance review/discipline mechanisms is required when an individual has acted:

- with intent to harm,
- recklessly, without regard for patient's welfare,
- impaired under the influence of drugs or alcohol, or
- with willful deviation from established policies, procedures, standards or guidelines.

5. ACCOUNTABILITY

The **PHSA** will demonstrate its commitment to patient safety through hazard identification by:

a) Establishing a policy outlining the events to be reported and the associated process.
b) Informing personnel about identifying and reporting hazards, injuries, harm, adverse events, and near misses in our PHSA agencies, and by providing education and training.
c) Welcoming comments, concerns, feedback and suggestions from patients, family members, and visitors.

The **PHSA** will demonstrate its commitment to creating a culture of safety in all PHSA agencies by:

a) Establishing a policy defining culture of safety and the expected associated behaviors.
b) Informing employees, students, volunteers, patients and families about a culture of safety and how it is promoted in our PHSA agencies.
c) Providing education and training to develop non-punitive interpersonal skills required to maintain a fair and just culture.

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

Patients, Families and Visitors
All patients, family members, and visitors in the PHSA agencies are encouraged to participate in creating a safer environment.

Appendix A: 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 outcomes of care include 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 or 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

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

are by definition adverse events and may be caused by error. CPSE also include product defects and protocol and process failures that potentially or actually result in an adverse outcome to patients, clients or the healthcare system. Within PHSA all CPSER are fromally reviewed.

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.

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