

Category: BOARD POLICY – ADMINISTRATIVE PARAMETERS	
Title: “Stop the Line”: Authority to Intervene to Ensure Patient Safety	Reference Number: AS 130
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 personnel in promptly detecting, appropriately intervening, and reporting unsafe situations in order to ensure patient safety and create a safer healthcare system.

2. POLICY

The PHSA is committed to patient safety, and to ensuring that all personnel understand their individual responsibility and authority to intervene to ensure patient safety by using the “stop the line” rule to clearly express patient safety concerns, and when asked to do so by others, to STOP and RESPOND to an expressed patient safety concern.

3. SCOPE

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

Although the STOP THE LINE policy focuses on preventing events that have the potential to seriously harm a patient, all personnel are expected to use “the rule” to stop any practice that has the potential to be harmful, regardless of the degree and likelihood of physical, mental, emotional, or psychosocial injury.

4. PROCEDURE

General

All personnel have the explicit responsibility and authority to immediately intervene to protect the safety of a patient, including protecting the patient from potential harm related to an adverse event, and/or averting a critical event.

Upon receiving a request to “Stop the Line”, personnel will immediately **STOP** and **RESPOND** to the expressed patient safety concern by:

- a) reassessing the patient’s safety and initiating appropriate actions to reduce patient harm.

- b) collaborating / consulting with team members to decide on the best plan of action.
- c) clearly communicating the plan of action to minimize patient risk and harm.

a) Types of Situations

Emergency Situations

When emergency intervention is warranted, assistance by the most expedient means available should be sought, including but not limited to:

- a) calling a Code Blue
- b) calling 911
- c) requesting immediate consultation
- d) transferring to a critical care area
- e) initiate escalation of care guidelines if available

Such necessary emergency interventions may be initiated without a physician’s order. However, orders for care are to be documented once the patient’s imminent risk is contained.

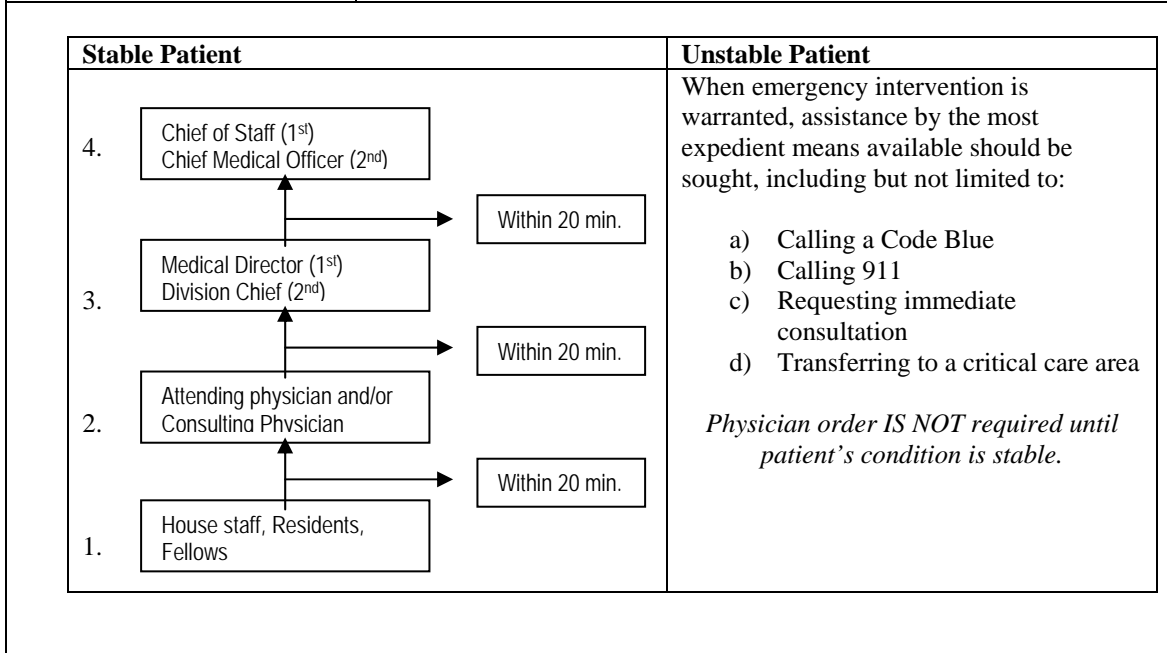
Situations Warranting Immediate Intervention	
Imminent Critical Event	<p>Examples:</p> <ul style="list-style-type: none"> • any event that may result in death or major injury not related to the patient’s natural course of illness or underlying condition • suicide of a patient • abduction of a minor child or discharge to the wrong family/person • sexual assault of a patient • assault of a patient • administration of blood or blood products not compatible with the patient/hemolytic transfusion reactions • surgery on the wrong patient or wrong body part • administration of any medication to which the patient has a known serious/life-threatening allergy • administration of any medication/substance that is not: <ul style="list-style-type: none"> a) the correct drug/substance b) the correct dose/rate c) the correct dilution d) being given at the correct time e) being given to the correct patient f) being given via the correct route

Imminent Adverse Event	Any event related to the provision of care that has potential to seriously harm a patient
Imminent violation of legally established patient rights that poses an immediate threat to patient safety	<p>Examples:</p> <ul style="list-style-type: none"> • failure to obtain informed consent • failure to perform an appropriate patient assessment and examination • failure to initiate a patient referral or transfer to a location best suited to deal with the patient’s health condition as determined by an appropriate assessment and examination
Caregiver under the influence	<p>When a care provider:</p> <ul style="list-style-type: none"> • exhibits behavior consistent with being under the influence of substances that impair judgment and/or manual skills • is witnessed taking substances that may impair judgment and/or manual skills during work time • discloses that they are under the influence of substances that impair judgment and/or manual skill during work time
Imminent patient safety risks not otherwise specified	<p>Imminent risk of potentially serious physical, mental or emotional harm due to:</p> <ul style="list-style-type: none"> • the patient being clinically unstable • inconsistent information about the procedure to be performed such as a discrepancy between the patient’s health record, the operating room schedule, the consent form, the patient’s expectations, or any other source of information used to guide clinical decision-making • any deviation from established protocol such as infection control practices • any misconduct related to research practices
Willful intent to do harm	Any knowledge that one person might have that another person has a willful intent to harm a patient or other person in the healthcare setting

b) Methods of Intervention

The method of intervention should be prioritized in an attempt to maximize timeliness and effectiveness in restoring patient safety while minimizing intrusion into the provision of essential/necessary care (minimize psychological trauma of the patient and/or the family and any further physical harm to the patient). Methods of intervention include:

<p>Direct Communication (i.e SBAR)</p>	<ul style="list-style-type: none"> • The reporter verbally communicates the identified safety issue directly to the care team member(s) • The reporter uses a consensually agreed upon code word or phrase that indicates a patient safety risk has been identified. Once the code word has been stated, the healthcare team member must immediately STOP and RESPOND
<p>Charge Nurse Notification</p>	<ul style="list-style-type: none"> • If the response to direct communication with the care team member(s) is not adequate to restore patient safety, the reporter contacts the charge nurse immediately
<p>Unit Manager/Supervisor Notification</p>	<ul style="list-style-type: none"> • If the response from the charge nurse is not adequate to restore patient safety, the reporter contacts the unit manager/supervisor immediately
<p>Communication Using the Chain of Command</p>	<ul style="list-style-type: none"> • If the response from the unit manager/supervisor is not adequate to restore patient safety, the reporter immediately follows this chain of command:



<p>Chain of Command Continued: Concerns Involving Medical Staff Members</p>	<ul style="list-style-type: none"> • If the response is still not adequate to restore patient safety, and if no other reasonable means of intervention are effective in restoring the timely, safe provision of patient care by the identified staff member, a senior medical administrator or the CEO will suspend the involved member’s privileges, and immediately assure that the patient receives proper, safe medical care until a medical staff member in good standing can assume the patient’s care. The Department Head initiates a timely assessment of the involved member’s practice issues. • Privileges remain suspended until: <ul style="list-style-type: none"> a) retracted by the Department Head b) a meeting of the credentials committee or MAC makes final recommendations to the board regarding the involved medical staff member’s privileges. • If the Department Head is unavailable or has a conflict of interest, the senior medical administrator is contacted. • In the absence of a vice president of medical affairs, the PHSA President and CEO is contacted.
<p>Chain of Command Continued: Concerns Involving Employees</p>	<ul style="list-style-type: none"> • If the “rule” is invoked due to concerns with the conduct, behavior or actions of an employee or person under contract to perform patient care services, the relevant manager is contacted. • If the manager’s response is not adequate to restore patient safety, the relevant director is contacted. • If the director’s response is not adequate to restore patient safety, the administrator on call is contacted. • If the administrator on call’s response is not adequate to restore patient safety, the agency President is contacted. • If the president’s response is not adequate to restore patient safety, the PHSA President and CEO is contacted.
<p>Concerns Involving Medical Equipment</p>	<ul style="list-style-type: none"> • The reporter immediately suspends the use of the equipment in question. • The reporter removes the equipment in question if the removal does not jeopardize patient safety. • The reporter tags the equipment in question and preserves all evidence pertinent to the equipment malfunction. • The reporter documents the equipment failure on an incident report form and notifies the area manager. • The area manager immediately notifies the individual responsible for product standardization, and the Department of Biomedical Engineering. If equipment failure was involved in a critical incident, the area manager also notifies the Department of Quality, Safety and Outcome Improvement. The Department of QS&OI

	responds immediately to gather and protect pertinent event information.
Concerns involving Environmental Hazards	<ul style="list-style-type: none"> • The reporter notifies the plant services manager. • If the response from the plant services manager or designate is not adequate to restore patient safety, the reporter contacts security. • If the response from security is not adequate to restore patient safety, the reporter contacts the administrator on call.

5. ACCOUNTABILITY

The PHSA will demonstrate its commitment to patient safety by:

- a) Establishing a policy outlining the STOP THE LINE process.
- b) Informing all personnel about using the STOP THE LINE rule to express a patient safety concern.

PHSA Personnel

All personnel are responsible for conducting themselves within the spirit of this policy and for appropriately using the “STOP THE LINE” rule to enhance patient safety.

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: Definitions¹

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.

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

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 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 CPSE are formally 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.

Policy Created on: June 22, 2006 Revision Dates:
