

Category: BOARD POLICY – ADMINISTRATIVE PARAMETERS	
Title: Critical Patient Safety Event Review	Reference Number: AS 150
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 when a critical patient safety event review (CPSE Review) needs to occur in a PHSA agency.

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 a critical patient safety event.

A critical patient safety event is defined as:

An event resulting in serious harm (loss of life, limb, or vital organ) or the significant risk thereof. Events are considered critical when there is an evident need for immediate investigation and response¹.

2. POLICY

The PHSA is committed to patient safety, and to ensuring that all personnel understand the process of critical patient safety event review within the larger context of hazard, adverse event and near miss identification and reporting, incident management and disclosure.

All critical patient safety events need to be formally reviewed as described in the PHSA Critical Patient Safety Event Review Tool Kit

(<http://pod/hcq/Critical%20Patient%20Safety%20Event%20Toolkit/Forms/AllItems.aspx>)

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

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 a critical patient safety event. All personnel associated with healthcare in the PHSA agencies are expected to follow established event reporting procedures regardless of event severity. Refer to the PHSA Critical Patient Safety

¹ BC Patient Safety & Learning System for the Provincial Health Services Authority (2009).
Note: Definitions and taxonomy are currently under review.

Event Review Tool Kit for complete information on roles and responsibilities for formal CPSE
(<http://pod/hcq/Critical%20Patient%20Safety%20Event%20Toolkit/Forms/AllItems.aspx>)

5. PROCESS

Within PHSA, the CPSE Review comprises six steps:

- a. Determine the Need for a Review
Determine the level of formality required for the review and identify those events that must be examined through a formal CPSE Review process.
- b. Form the Review Team
Form a representative multidisciplinary team to conduct a RCA
- c. Gather Information
Collect thorough and relevant information on the event
- d. Conduct Root Cause Analysis
Implement the RCA process by reviewing the information collected, determining contributing factors and root causes to formulate causal statements
- e. Generate Recommendations and Report
Develop and implement recommendations to mitigate root causes. Report the overall CPSE Review process and findings.
- f. Share Learnings from Critical Patient Safety Event Findings
Determine the need for broader sharing of review findings with others to promote patient safety.

6. ACCOUNTABILITY

The PHSA will demonstrate its commitment to patient safety following a critical patient safety event by establishing a policy outlining the roles and responsibilities involved in investigating the critical patient safety event and communicating information and recommendations.

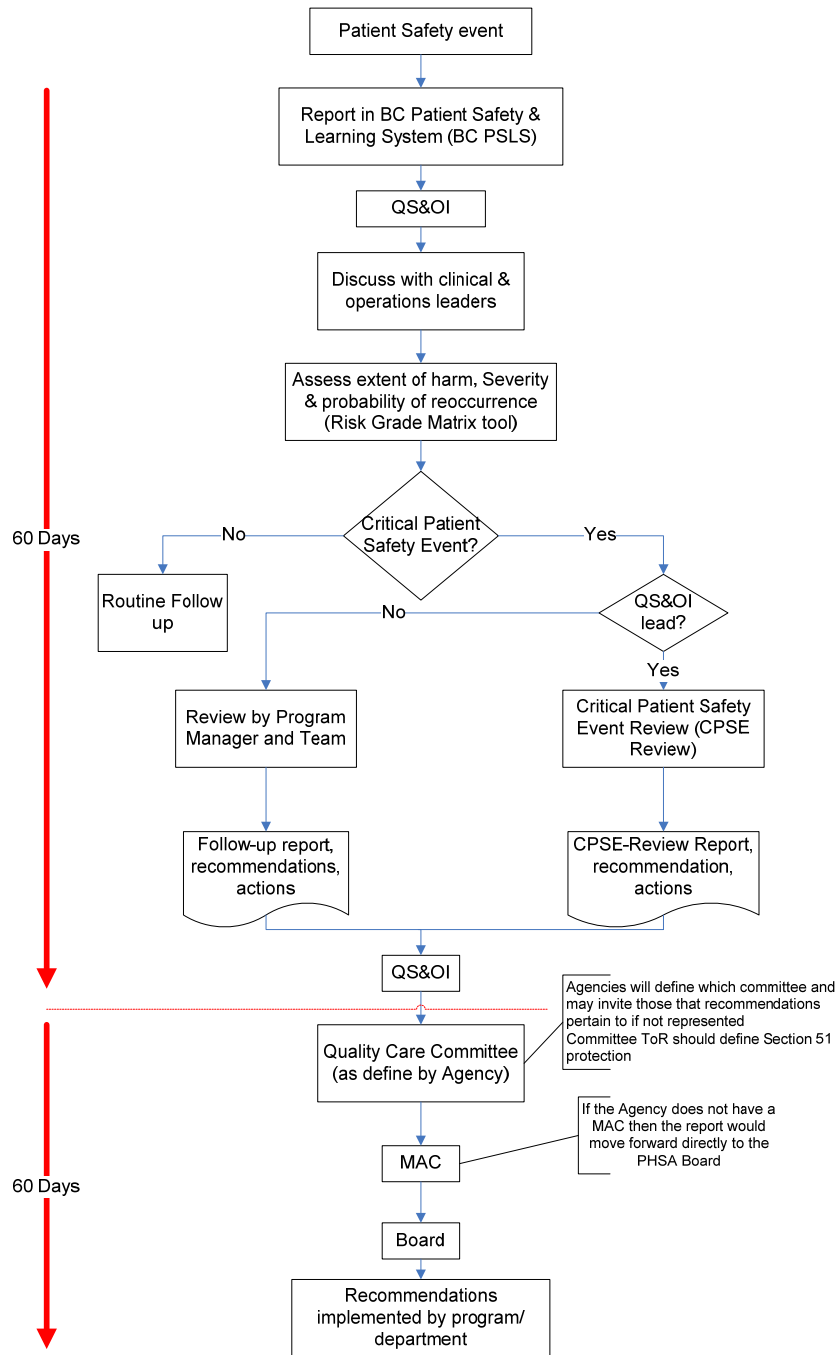
PHSA Personnel

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

If you have questions or need assistance with policy implementation, contact your Manager, your Quality Lead, Risk and/or the Quality Director for your agency.

Appendix A: Adverse Patient Safety Event Reporting Process

The following is a process outline of a review when an adverse event is determined to be critical



Appendix B: Patient Safety Events Requiring Critical Review in the PHSA

Please refer to your agency specific list as each agency has additional criteria that warrant critical reviews.:

Product or device events
1.1 Patient death or serious disability associated with the use of contaminated drugs, devices or biologics regardless of the source and/or product
1.2 Patient death or serious disability associated with the use or function of a device in patient care in which the device is used for functions other than intended
1.3 Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility

Patient protection events
2.1 Infant discharged to the wrong person Patient discharged to the wrong person
2.2 Patient death or serious disability associated with elopement (disappearance)
2.3 Patient suicide or attempted suicide, resulting in serious disability while being cared for in a healthcare facility Attempted or actual suicide while undergoing care by a healthcare facility
2.4 Patient death or serious disability associated with elopement (disappearance), escape or unauthorized leave

Care management events
3.1 Patient death or serious disability associated with a medication error (e.g. errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration) Patient death or serious disability associated with a serious volume error (etc. TPN, blood/blood products)
3.2 Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products
3.3 Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility
3.4 Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility
3.5 Patient death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates
3.6 Known death or serious injury within 48 hours following a visit or discharge from an acute healthcare facility

3.7 Loss of a body from pathology or a specimen block
3.8 Failure in a surveillance system process leading to significant harm due to a delay in detection of an outbreak
3.9 Failure of the standardized contact tracing process for newly diagnosed HIV and TB patients resulting in significant harm to a patient or population
3.10 Missed chemotherapy dose
3.11 System or process error resulting in communication of incorrect diagnosis to patient

Surgical Events
4.1 Unintended retention of a foreign object in a patient after surgery of other procedure
4.2 Surgery performed on the wrong body part
4.3 Surgery performed on the wrong patient
4.4 Wrong surgical procedure performed on a patient
4.5 Intraoperative or immediately post-operative death in a healthy patient
4.6 Transplant of wrong organ or removal of an incorrect organ
4.7 Unexpected death in community when surgical procedure performed within prior 7 days
4.8 Patient death or serious disability associated with an incorrect procedure (e.g. errors involving the wrong procedure, wrong patient, wrong location, wrong indication, wrong time)

Environmental events
5.1 Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility
5.2 Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
5.3 Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility
5.4 Patient death or serious disability associated with a fall while being cared for in a healthcare facility
5.5 Patient death or serious disability associated with the use of restraints or bedrails while being care for in a healthcare facility

Criminal events
6.1 Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider

6.2 Abduction of a patient of any age
6.3 Sexual assault or significant physical assault on a patient within or on the grounds of a healthcare facility
6.4 Death or significant injury of a patient or staff member resulting from a physical assault (i.e. battery) that occurs within or on the grounds of a healthcare facility

Obstetric events
7.1 Maternal Death
7.2 Intrapartum or Neonatal Death >2500 g
7.3 Uterine Rupture
7.4 Maternal Admission to ICU
7.5 Birth Trauma: Intracranial laceration and hemorrhage due to birth injury, other birth injuries to CNS. Birth injuries to scalp or skeleton, brachial plexus injuries, other birth injuries
7.6 Admission to NICU >2500 g & for > 24 hrs with Apgars < 7 at 5 minutes
7.7 Mass obstetrical hemorrhage (MOH) with hysterectomy and/or embolization > 4 units units of packed cells

The preceding list is based on:

National Quality Forum (2007). Serious reportable events in healthcare 2006 update: A consensus report. Washington DC: Author.

and

Mann, S. et al. (2006). Assessing quality in obstetrical care: Development of standardized measures. *Joint Commission Journal on Quality and Patient Safety* 32 (9), 497-505.

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