POLICY TITLE

PATIENT SAFETY EVENT MANAGEMENT

AUTHORIZATION	DATE APPROVED	DATE REVISED
Clinical Executive Committee	August 2009	

INTRODUCTION

Fraser Health is committed to providing quality care to its patients[1], as described in its Vision, Mission and Values, recognizing that safe health care is its first priority.

PURPOSE OF THIS POLICY

The purpose of this policy is to establish accountability throughout Fraser Health for:

- Reporting of patient safety events
- Support for health care providers
- Analysis of patient safety events for improvement

Patient safety event management is one element of Fraser Health's commitment to patient safety. The other elements are:

Just and Trusting Safety Culture **–** Fraser Health's commitment to be fair and transparent in assessing the behaviors of health care providers when they are involved in safety occurrences to ensure that they are not discriminated against due to involvement in or reporting of a harm event and that they are supported when distressed by a patient safety event.

Disclosing Harm – (See Fraser Health Policy: "*Disclosure of Harm to Patients"*)

Informing Stakeholders of Safety Hazards **–** Fraser Health's commitment to be open and transparent in fulfilling its duty to inform both internal and external stakeholders where there is real or perceived risk to the health of individuals or where safety concerns may adversely impact the public's confidence in the health care system.

SCOPE

This Policy applies equally to all individuals associated with Fraser Health including:

- Employees
- Volunteers
- Physicians with privileges at any facility

[1] Refer to "Definitions" found on page 6 of this policy

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- Medical staff including physicians on contract, resident and clinical trainees
- Health service providers as defined in contractual agreements governing their service mandate

APPLICABLE LEGISLATION

Fraser Health acknowledges and complies with applicable legislation relating to patient safety reporting specifically to protect the information collected under section 51 of the B.C. Evidence Act.

POLICY

Reporting of Harm and Safety Hazards

A complete, accurate and factual account of a patient safety event *is the responsibility of any individual who discovers or has knowledge of the event*. This is recorded either on the HIRS ENCON form or the web-based Patient Safety and Learning System (PSLS) on-line form (whichever tool is available).

♦ Circumstances Under Which Reporting ***Must*** Occur

Fraser Health requires that health care providers, as defined under the scope of applicability of this policy, report events where patients have been harmed while receiving care or service. Reporting of patient safety events must occur for any adverse event which has resulted in harm, injury or complication due to health service delivery, such as the administration of an incorrect dosage of a medication.

♦ Circumstances Under Which Reporting ***Should*** Occur

Fraser Health encourages and supports the reporting of safety hazards that may lead to harm for the purpose of continuous improvement of systems to keep patients safe while receiving care or service. Reporting *should* occur in the following situations by any member(s) of the health care team who identifies a potential patient safety issue such as any event whereby:

- the patient has *nearly been harmed* (a safety hazard that could have caused harm but were intercepted *before* it reached the patient)*;*
- remedial steps are required to address any immediate care needs of the patient;
- the safety hazard might provide insight into circumstances which could be used to prevent actual patient harm and improve care processes.

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Support for Health Care Providers

Health care team members involved in a patient safety event are often affected by the event and their role in it. Support should be offered by the Program/Service leadership to members of the health care team involved in a patient safety event as required.

Analysis of Patient Safety Events

Within **3 Business Days** of a Patient Safety Event, the role of the Manager, Program/Service Director, Quality Improvement and Patient Safety Consultant and Vice President is as follows:

Manager or Designate

All harm or safety hazards reported through Fraser Health's event reporting systems (HIRS ENCON or PSLS) must be followed up by the Manager or designate in charge of the area. Responsibilities for follow-up at this level include:

- confirming/modifying the degree of harm associated with the event (see *Patient Safety Toolkit);*
- ensuring appropriate notification of the event to the most responsible physician and other departments as applicable, such as Pharmacy and Biomedical Engineering, to request participation in follow-up of the event;
- ensuring that if the severity level of the event is classified between *moderate harm and death*, the Program/Service Director and Quality Improvement and Patient Safety are notified (NOTE: this occurs via e-mail auto-notification where PSLS is available);
- ensuring that if the severity level of the event is classified as either *serious harm or death*, the most responsible Vice President is also notified.

Program/Service Director: Events Ranging from Moderate Harm to Death

The Program/Service Director is responsible to:

- support the Manager or designate in follow-up of patient safety events;
- ensure notification of the Program/Service Executive Director and Medical Director of events with outcomes ranging from *moderate harm to death.*

Executive Director and Medical Director: Events Ranging from Moderate Harm to Death

The Program/Service Executive Director and Medical Director are responsible for:

- ensuring Administrative and Medical leads have been identified and ensuring timely and effective review of the event by the most appropriate team members in their areas;
- communicating events resulting in *serious harm or death* to the appropriate Vice President along with recommendations for the type of review to be conducted;

- notifying Communications and other stakeholders of the event as appropriate;
- decisions related to actions on recommendations arising from review of the event.

Quality Improvement and Patient Safety Consultant

Upon notification of a patient safety event, the Quality Improvement and Patient Safety Consultant will:

- support the Manager/designate and Program/Service Leadership Team (i.e. Executive Director, Medical Director and/or Director) to conduct an initial assessment of the event to determine whether it meets criteria for:
  - a Patient Safety Review (i.e. inter-disciplinary root cause analysis review of the factors contributing to the event) (see *Patient Safety Event Management Education Module and Handbook);*
  - an Administrative Review (i.e. operational review)
  - a Medical Management Review (i.e. third-party peer review);
- ensure that Integrated Risk Management has been advised of the event if there is potential for claim associated with it.

If the patient safety event requires a process review using *root cause analysis*, the Quality Improvement and Patient Safety Consultant or other member of the health care team with expertise in this area will facilitate this process once commissioned by the most responsible Vice President.

The Quality Improvement and Patient Safety Consultant also liaises with the commissioner of the review to ensure it is recorded, along with status of recommendations, in a Patient Safety Review database/PSLS Actions Module.

Vice President: Events Resulting in Serious Harm or Death

The Program/Service Vice President is responsible for:

- commissioning a formal review of patient safety events which have resulted in serious harm or death;
- designating the Administrative and Medical leads for the formal review of such patient safety events;
- for decisions related to actions on recommendations arising from review of the event.

Note:

If the patient safety event requires either an Administrative or Medical review, it is to be led and managed by the Administrative and/or Medical leadership and, as such, is outside the scope of a root cause analysis.

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In the event of conflicting opinions about the type of review to be conducted, the final decision rests with the most responsible Vice President. As a review proceeds, it may become evident that more than one type of review is required. In such cases, each type of review will be conducted independent of each other.

Within 30 Business Days of the Event - Review Completion

The timeframe for completion of the review is **30 days**. If complexity associated with the event or other factors necessitate an extension this must be negotiated with the commissioner of the review and monitored on a specified basis.

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DEFINITIONS

Commissioning - the act of granting authority to undertake certain functions.

Disclosure - the process used by health professionals to inform a patient of a specific harm event and the implications of that event, if any, for the course of the patient's care.

Harm – an unexpected or normally avoidable outcome that negatively affects a patient's health and/or quality of life and occurs or has occurred during the course of receiving health care or services from Fraser Health.

Safety Hazard – is defined as a situation where there was a high likelihood (greater than 25%) an adverse event would occur and a patient would have been harmed but the potential for harm was recognized and a successful action was taken which prevented actual harm. These situations are often referred to as 'close calls', 'near misses' or 'good catches'.

Patient - An individual who receives care or services from a health care agency within a Health Authority in B.C. This definition is inclusive of patients, residents or clients in their respective acute, residential or community settings. This may include their families and, where appropriate, substitute decision makers.

RELATED DOCUMENTS

- ENCON Guidelines for Completion of HIRS/ENCON Forms
- ENCON Incident Report Flowchart
- FHA WEB: *Patient Safety and Learning System (PSLS)* WEB Page: *Report and Manage Safety Events*
- Patient Safety Event Management Toolkit:
  - Protocol
  - Parameters of Commissioning a Review of a Patient Safety Event
  - Guideline for Commissioning Patient Safety Reviews
  - Patient Safety Heat Map
  - Incident Decision Tree
- Fraser Health Policy: *"Disclosure of Harm to Patients"*

For more information related to this policy, please contact the Quality Improvement and Patient Safety Consultant designated for the applicable Program or Service area. To identify the most appropriate Quality Improvement and Patient Safety Consultant, please contact 604.587.4633.

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REFERENCES

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