Title:	HARMFUL INCIDENTS		**No.: GEN.5.30.10**
Section:	5. Risk Management, Quality and Patient Safety	**Effective date:**	**2017-03-27**
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Facility/ program:			

PURPOSE

To ensure that harmful incidents are analyzed to determine root causes and take corrective action to prevent similar events from reoccurring in the future.

DEFINITIONS

Patient safety incident: An event or circumstance which might have resulted, or did result, in unnecessary harm to a patient.

Incident: An event which has resulted in, or has the potential to result in, injury and/or loss to a patient, an employee, a physician, a visitor, a volunteer, a student, or any other person, or to the property, equipment and/or reputation of the Network (e.g. fall, medication error, or trauma related to treatment).

Harmful incident: A patient safety incident that resulted in harm to the patient. Replaces “adverse event,” “sentinel event” and “critical incident.”

Near miss: An event or circumstance that could have resulted in an injury or illness in a patient, but did not through timely intervention.

POLICY

1. All harmful incidents must be handled and documented appropriately, in accordance with the Management of Incidents and Near Misses policy GEN.5.20.10.
   1.1. All harmful incidents must be promptly investigated to determine the causes and corrective action. An algorithm of the process is presented in Appendix **GEN.5.30.10 (1)**. The Incident Decision Tree in Appendix GEN.5.30.10 (2) will serve as a guide to determine whether a review should be done.

2. The Quality and Patient Safety Department Advisor is responsible for:
   2.1. Determining, in consultation with the Risk Management Department, whether a review is needed;

2.2. Coordinating the meeting process by inviting the appropriate members to form the Quality and Patient Safety Review Committee;

2.3. Controlling the necessary documents by presenting them for the review and getting them back afterwards;

2.4. Ensuring that recommendations are documented and follow-ups are done and reported to the Client Service, Quality Management and Safety Regional Committee.

3. The zone's review committee examines the case, analyses the root causes, and makes and follows ups on all appropriate recommendations.

4. If the event is only related to a professional's competency, the regulations governing the field of practice of that professional and the manager involved (and not this policy) will dictate the procedure to handle this event. This decision will be made in consultation with the professional authority concerned. Follow-ups will be done at that level and not by the committee.

5. All documenting must comply with the following:

5.1 Documenting must be accurate and factual;

5.2 Oral communication must be the preferred method of communication; correspondence via e-mail shall be limited;

5.3 No copies of the follow-up or review report shall be made;

5.4 No personal notes shall be made or kept by individuals concerned unless requested by Risk Management;

5.5 All documents shall be marked, "PRIVILEGED AND CONFIDENTIAL - FOR QUALITY IMPROVEMENT PURPOSES."

PROCEDURE

1. **<u>Immediate control of the incident</u>**

The care team responds to an event immediately in order to meet the needs of the patient and staff concerned, make the area safe, gather the facts, and inform the appropriate people.

1.1 **The manager, delegate or person in charge of the care team/services:**

1.1.1 Ensures that the immediate needs of the patient and family are met;

1.1.2 Immediately notifies the following people:

- Department/unit manager;
- Attending physician;
- Risk Management Advisor;
- Director of the department/unit or duty officer;

1.1.3 If an event occurs in the evening, at night or on the weekend, notifies the supervisor and duty officer, and the duty officer notifies the Risk Management Advisor on the following working day;

1.1.4 Removes and places in a safe location the medication, material, or equipment that may have contributed to the incident;

1.1.5 If the event is linked to malfunctioning equipment, removes the equipment and places a “Do not use” sign; then contacts the Clinical Engineering Department (do not clean, repair or dismantle the equipment);

1.1.6 Ensures that all the necessary clinical information surrounding the event is documented in the patient's file;

1.1.7 Completes an incident report;

1.1.8 Takes into account the immediate needs of the staff (e.g., stress management, debriefing, Employee/Family Assistance Program), as well as those of other patients, families, and visitors.

1.2 **At the time of the incident, the attending physician:**

1.2.1 Responds to the immediate needs of the patient and family;

1.2.2 In collaboration with the individuals concerned, informs the patient of the incident in accordance with the Harmful Incident Disclosure policy GEN.5.30.20;

1.2.3 Provides ongoing support and keeps the patient or the patient’s substitute decision maker informed, as may apply;

1.2.4 Notifies his or her Department Head, who notifies the Chief of Staff of the zone;

1.2.5 Notifies the family physician, if applicable;

1.2.6 Ensures that the coroner is notified in case of unexpected death.

1.3 **The Risk Management Advisor:**

1.3.1 Verbally informs his or her manager and, as needed, the appropriate authorities (e.g., director, VP, police);

1.3.2 Provides support to employees and the department/unit manager in controlling and documenting the event, ensuring that all the facts are accurately and clearly documented;

1.3.3 Gathers:

- the names of staff members involved in the event;
- copies of relevant procedures and protocols;
- copies of relevant documents (e.g., kardex, medication sheet, etc.);
- copies of rounds and staff assignments;
- the names of other patients, family members, and visitors in the room;
- the equipment, medical devices, department manual, serial number and model number, if applicable (with the assistance of the Clinical Engineering Department);
- initiates the process to secure the patient’s clinical file;
- receives and compiles all documents for risk management and review purposes;
- prepares a status report for the Review Committee.

2. Review of harmful incidents and root causes analysis

This is the process by which each serious incident is reviewed and analyzed to identify the causes and make the necessary improvements to prevent similar events from reoccurring.

2.1 **The Quality and Patient Safety Department Advisor acts as a facilitator for the Review Committee (of the zone) and:**

2.1.1 Gathers:

- all relevant documents and data in the file;
- all related policies and procedures;
- all information provided by other sources (e.g. Risk Management);

2.1.2 Uses the Incident Decision Tree [Appendix GEN.5.30.10 (2)] to determine in collaboration with key players whether a review is required;

2.1.3 Opens a "Review of Harmful Event" file and compiles all additional information. No other copy than the one required for the review must be made and additional copies must be destroyed after the review;

2.1.4 Calls a meeting of the Harmful Incident Review Committee as soon as possible;

2.1.5 Facilitates the meeting and coordinates the harmful incident review and analysis;

2.1.6 Prepares a report on reviews for the Client Services, Quality Management and Safety Regional Committee.

2.2 **Harmful Incident Review Committee**

2.2.1 The committee reviews all written material.

2.2.2 The committee conducts a root cause analysis, identifies and prioritizes areas for improvement or required safeguards and draws up all appropriate recommendations, while staying within the parameters of the process and of its role.

2.2.3 The Quality and Patient Safety Department Advisor of the zone presents a summary report with recommendations for improvement to the Director and Vice-President concerned as well as to the Client Services, Quality Management and Safety Regional Committee.

3. **Resolution and follow-up**

3.1 The Client Services, Quality Management and Safety Regional Committee reviews the summary report, confirms feasibility and prioritization, and approves recommendations. The committee also recommends an action plan, assigns the appropriate people, and oversees the implementation and regionalization, if needed, of recommendations.

3.2 A summary of factual information on the event and recommendations produced from the analysis is kept by the Quality and Patient Safety Department.

3.3 The Vice-President, Performance, Quality and Corporate Services presents a summary of conclusions to the Board of Directors through the Client Services, Quality Management and Safety Regional Committee.

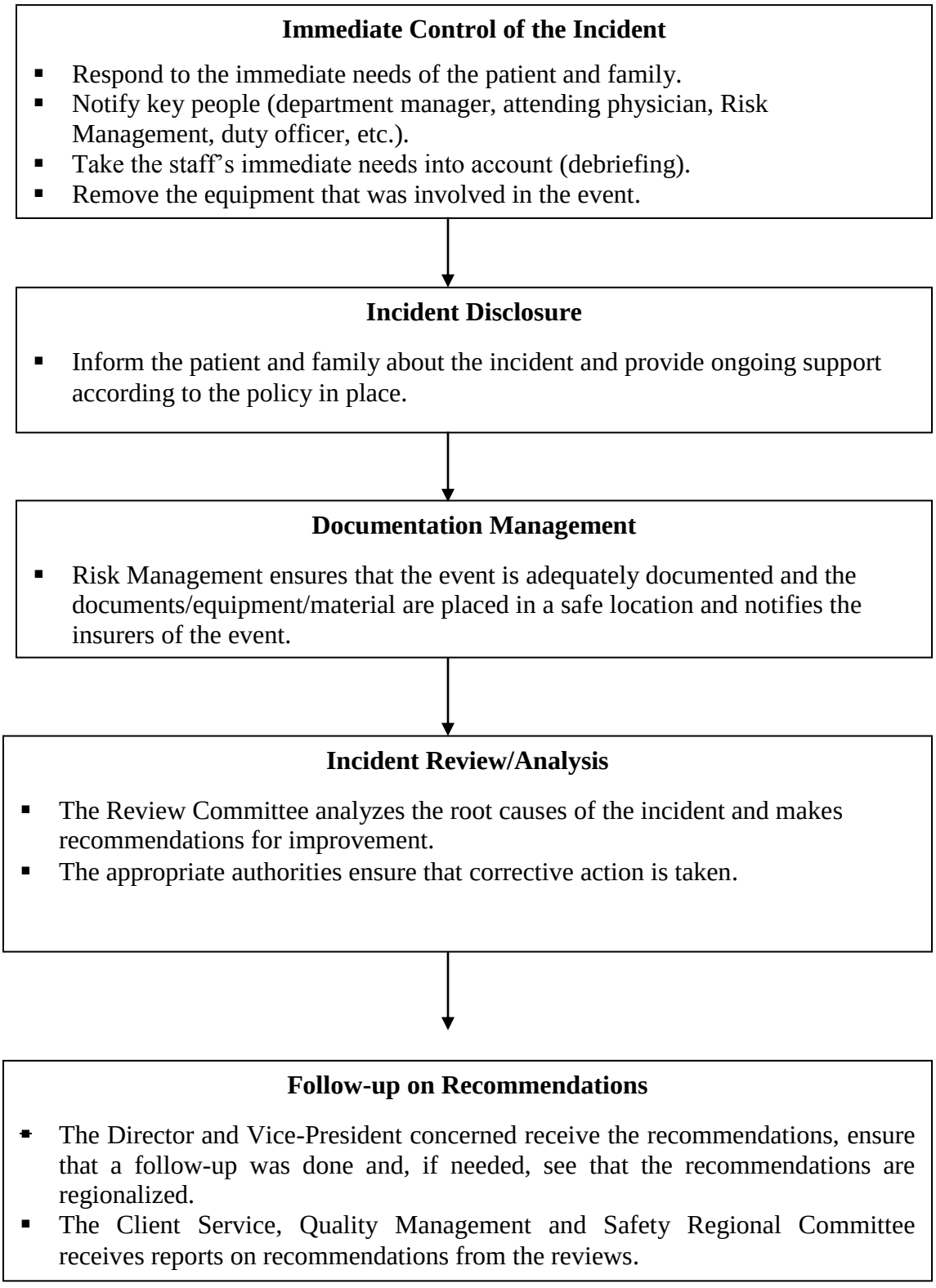
ADDITIONAL RELEVANT INFORMATION

1. The root cause analysis is an in-depth evaluation; its purpose is to identify the underlying causes of an adverse event or system problems in order to prevent the event from reoccurring. The analysis:
   - 1.1 focuses on systems and processes, not individual performance;
   - 1.2 starts with obvious causes of the event and progresses until the causes of all adverse events/problems in systems/processes are identified;
   - 1.3 becomes more exhaustive with each step and the question "why" continues to be asked until no further logical answers can be identified;
   - 1.4 identifies possible system/process changes by modifying existing systems/processes or developing new ones that will improve performance and reduce the risk of similar events reoccurring in the future.

REFERENCES

1. Institut canadien pour la sécurité des patients (ICSP), *Guide canadien de l'analyse des causes souches,* décembre 2008.
2. *Glossaire canadien sur la prestation sécuritaire des soins et services au patient,* 2003.
3. Agrément Canada, *Guide de référence sur les événements sentinelles.*
4. *Cadre canadien d'analyse des incidents, http://www.patientsafetyinstitute.ca/fr/toolsresources/IncidentAnalysis/Documents/Canadian%20Incident%20Analysis%20Framework%20FR.PDF*
5. *PROJET DE LOI 35, Loi sur la qualité des soins de santé et la sécurité des patients, Troisième lecture : 2016-5-18*

HANDLING OF A HARMFUL INCIDENT



APPENDIX GEN.5.30.10 (2)