Title:	INCIDENTS AND NEAR MISSES		**No.: GEN.5.20.10**
Section:	5. Quality, Risk Management, and Patient Safety	**Effective date:**	**2017-03-27**
Issuing authority:	Director of Risk Management and Regional Privacy Officer	**Date of last revision:**	2012-09-10
Approver:	President and CEO Gilles Lanteigne	**Approved on:**	2017-03-09
Facility/ Program:			

PURPOSE

To define mechanisms for management of incidents and near misses, as well as the roles and responsibilities of the staff.

DEFINITIONS

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

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

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

Incident analysis: A structured process that aims to identify what happened, how and why it happened, what can be done to reduce the risk of recurrence and make care safer.

POLICY

1. Any incident/near miss must be reported in accordance with the reporting system in place in the zone by the person who witnessed it or observed that it occurred.
   - 1.1 The incident must be documented on an incident report before the end of the shift during which it occurred or was observed.
   - 1.2 If the required computer system is not available, a paper report must be filled out.
   - 1.3 Notes documented on the incident report must be brief, accurate, and factual, devoid of opinions and accusations.
     - 1.3.1 All patient-related incidents must be documented in the patient's record by the appropriate clinical staff.

1.4 Notes in the patient's record must only include the facts related to the incident, action taken, as well as the name and title of each person who was notified of the incident (e.g. supervisor, physician, family member).

Note: The incident report must not be included or mentioned in the patient's record.

2. All incidents and near misses must be reviewed by the appropriate manager or delegate.
   2.1 The manager must initiate a follow-up within 5 working days and ensure that timely corrective action is taken.
   2.2 Employees must participate in the investigation/follow-up when necessary.
   2.3 The manager must document the follow-up done, including corrective action or improvements required, within 30 days (if a paper report is used, return it to the Risk Management Department).

3. Only the Risk Management Department has the right to reproduce an incident report and other follow-up documents.

4. The information in an incident report must be treated as confidential.

5. The Risk Management Advisor:
   5.1 Provides support to managers during the investigation and follow-up process;
   5.2 Assigns incident reports (for follow-up) to the appropriate departments;
   5.3 If the event affects more than one department, coordinates the follow-up process, as needed, with the managers and other individuals involved;
   5.4 Consults, as necessary, the clinical staff, experts, or any other resource that can provide additional information;
   5.5 Informs management or any other interested individuals in the event of a severe incident;
   5.6 For severe incidents requiring a review, consults the Quality and Patient Safety Department Advisor in accordance with the Management of Adverse and Sentinel Events policy GEN.5.30.10;
   5.7 Sends senior management and managers a quarterly report on incidents and near misses.

PROCEDURE

1. The care team or appropriate manager takes immediate control of the incident. All adverse events must be managed in accordance with policy and procedure GEN.5.30.10.

2. The person who observes the incident or near miss informs their immediate supervisor (or department manager) immediately and completes an incident report **before the end of their shift**.

    2.1 Any incident with serious consequences must be reported to the manager immediately as well as to the Risk Management Department as quickly as possible.

3. If the incident is due to malfunctioning equipment, the equipment is removed from the department, a “Do not Use” sign is posted on the equipment, and the Clinical Engineering Department or Facilities Management Department is contacted, as may apply (do not clean, repair or dismantle the equipment).

4. As soon as the incident report is completed, it is given or assigned (depending on the system in place) to the manager concerned so that he may conduct a situation analysis, ensure follow-up, and suggest solutions.

5. The Risk Management Department staff review the incident reports to validate the information and provide support to managers.

6. The Risk Management Advisor contacts the person who completed the incident report (or the person’s manager) to obtain any missing information or correct information, as necessary.

7. If a paper incident report is used, the incident report is returned to the Risk Management Department after it has been completed.

8. Once all follow-ups have been done, the Risk Management Department closes the incident file. If the response time has elapsed, a reminder is given to the managers concerned.

9. In accordance with policy GEN.5.30.20, any incidents, except near misses, must be disclosed to the patient. This step must be documented on the incident report.

ADDITIONAL RELEVANT INFORMATION

1. The date of the incident (Occurrence Date) corresponds to the date on which the incident occurred and not the date on which the incident report is completed (Date Reported).

2. The purpose of the follow-up process for incidents and near misses is to learn from them, reduce recurrence, and strengthen the culture of safety through ongoing improvement of quality.

REFERENCES

1. Programme QMentum d'Agrément Canada, Cahier de normes sur la direction, version 7 (2012).

2. Healthcare Incident Reporting System « HIRS »

3. Legal advice, April 12, 2016, Cox & Palmer.

4. ***** Canadian Incident Analysis Framework : http://www.patientsafetyinstitute.ca/en/toolsResources/IncidentAnalysis/Documents/Canadian%20Incident%20Analysis%20Framework.PDF#search=incident%20management%20framework

5. *Health Quality and Patient Safety Act*, Assented to June 28, 2016