Safety Incident Management

Please note: The policy description, purpose and outcomes are harmonized across the Huron Perth & Area Ontario Health Team Accreditation Collaborative.

Policy

The Huron Perth and Area Ontario Health Team (HPA-OHT) supports a harmonized approach to monitoring and managing incidents associated with staff/patient/client/resident/visitor/family/caregiver safety. The partner organizations of the HPA-OHT are committed to the provision of high quality, safe and reliable care to patients/clients/residents and families and to ensuring a safe work environment for our staff and visitors. To support this goal, the HPA-OHT organizations are committed to the timely management of events as an important strategy for fostering a culture of safety, timely reporting of incidents and for ensuring that staff is involved in the feedback loop.

Reporting of safety incidents and the management thereof provide opportunities to identify safety gaps within the system, trend events, track follow up, and highlight opportunities for improvement. Effective management of safety incidents advances the ability of HPA-OHT organizations to improve outcomes, learn from experiences and initiate system improvements thereby minimizing the risk of harm to client/patient/resident/visitors and staff.

Purpose

This policy provides guidance to the partner organizations of the Huron Perth and Area Ontario Health Team to effectively manage incidents involving staff, patients/clients/residents, visitors, and family members/caregivers. This policy applies to all areas of the workplace.

Guiding Principles

The following foundational principles will guide a culture of safety and accountability in which employees, providers, students and volunteers are supported within an open and transparent environment to manage actual or potential safety incidents and/or hazards.

- All employees, providers, students and volunteers of the HPA-OHT organizations are accountable for the delivery of high quality, safe, reliable care
- The organizations of the Huron Perth and Area Ontario Health Team will:
    - Promote and support a just culture* that encourages reporting of hazards
    - Appreciate that incidents typically occur as a result of staff working within complex systems

A “just” culture refers to a values-supportive model of shared accountability. It is a culture that holds organizations accountable for the systems they design and for how they respond to staff behaviors fairly and justly. (Health Leaders Media, May 2010)

- All employees, providers, students and volunteers of the HPA-OHT organizations are accountable to promptly report occupational accidents, incidents, hazardous conditions, near misses and non-injury property damage.
- In response to reports of safety issues, the partner organizations of the Huron Perth and Area Ontario Health Team will:
    - Provide a safe work environment
    - View incidents as opportunities for learning
    - Ensure a timely and transparent evaluation of all systems factors that might have influenced the incident occurs
    - Take appropriate actions to mitigate risk of recurrence of similar incidents
    - Support and value the participation of employees, providers, students and volunteers in the review and incident analysis process
- Review and track all safety incidents via reporting programs to identify safety trends that require improvements.
- The organizations of the HPA-OHT have an obligation to address the actions of individual(s) that fail to meet the professional standards of care or service including:
    - Intentional acts to harm a patient/client/resident or co-worker
    - Rough, boisterous actions (horseplay) that may or may not result in injury
    - Suspicion of physical, mental or emotional impairment of employees, providers, students and volunteers
    - Suspicion of substance abuse by employees, providers, students and volunteers
    - Suspicion of inability to practice responsibilities safely despite education and counselling of the employee, provider, student or volunteer.

Definitions

Actions taken to reduce risk	Proactive or reactive actions to reduce, manage or control future harm or probability of harm associated with an incident.
Adverse Event	Preferred term is “Harmful Incident: (see definition below)
Adverse Drug Event	An injury resulting from a medication or lack of an intended medication; includes adverse drug reactions and harm from medication incidents.
Adverse Drug Reaction:	Is a subset of medication events that includes any clinical manifestation that is undesired, unintended or unexpected as a consequence to and caused by the administration of medications.
Contributing Factor	A circumstance, action or influence that is thought to have played a part in the origin or development of the increased risk of an incident.

	May be considered as a necessary action pre-empting an incident but may/may not be sufficient to cause the incident.
Critical Incident (Employee)	As defined under the *Occupational Health & Safety Act:* An Employee injury of a serious nature that: • Places life in jeopardy • Produces unconsciousness • Results in substantial loss of blood • Involves the fracture of a leg or arm but not a finger or toe • Involves the amputation of a leg, arm, hand or foot but not a finger or toe • Consists of burns to a major portion of the body • Causes loss of sight in an eye
Critical Incident (Hospital Patient)	Defined under the *Public Hospitals Act* as: Any unintended event that • occurs when a patient received treatment in a hospital **AND** • results in death or serious disability, injury or harm to the patient **AND** • does not result primarily from the patient's underlying medical condition or from a known risk inherent in providing treatment Preferred term is "Harmful Incident" (see definition below)
First Aid Incident (Employee)	Employee sustains a work-related injury requiring only first aid.
Harm (Patient/Client/Resident)	Impairment of structure or function of the body and/or any deleterious effect arising as a result. May be physical, social or psychological impairment Harm includes disease, injury, suffering, disability and death • Disease: physiological or psychological dysfunction • Injury: damage to tissues caused by an agent or event • Suffering: experience of anything subjectively unpleasant i.e. pain, malaise, nausea, depression, agitation, alarm, fear, grief • Disability: implies any type of impairment of body structures or function, activity limitation and/or restriction of participation in society associated with past or present harm

Harmful Incident (Patient/Client/Resident)	• Defined by the Canadian Patient Safety Institute (CPSI) as unexpected safety incident in healthcare delivery that result in immediate or future harm and is not attributed to a recognized complication or known risk inherent in providing treatment or result primarily from an underlying medical condition. • Disclosure is required by the organization and requisite laws should occur following harmful incidents. • Include complications and side effects of treatment, extended length of stay, need for additional treatment(s), death or serious disability. Harmful incidents are not necessarily markers of substandard care. • Alternative to “adverse event” and “sentinel or critical event” • Also see Patient Safety Incident
Healthcare Associated Harm	Harm arising from or associated with plans or actions taken during the provision of healthcare, rather than from underlying disease or injury
Incident characteristics	Selected attributes of an incident such as care setting, treatment status, health disciplines involved and date of incident.
Lost Time Incident (Employee)	Employee sustains a work-related injury, which results in lost time from work after the day of the accident.
Medical Aid Incident (Employee)	• Employee sustains a work-related injury when there is no lost time from work, other than on the day of the incident and receives medical attention from a chiropractor, provider, physiotherapist, or registered nurse (extended class) • The Workplace Safety and Insurance Board covers the health care costs resulting from the injury.
Near Miss (Patient)	An incident that did not reach the patient
No Harm Incident (Patient)	A safety incident which reached the patient but no discernable harm resulted
Patient/Client/Resident Safety	The reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum
Patient/Client/Resident Safety Incident	Defined by the Canadian Patient Safety Institute (CPSI) as an incident which could have resulted, or did result in, unnecessary harm to a patient/client/resident and includes: • Harmful Incident • No Harm Incident • Near Miss

Patient Partner/Patient Advocate/Volunteer	A person other than a patient/client/resident or staff member working within the organization in a volunteer capacity
Preventable	Accepted by the community as avoidable in a particular set of circumstances
Quality of Care (QoC) Meeting (Hospital Patient)	A confidential meeting, protected under the *Quality of Care Protection Act* (QCIPA), to ➢ Promote quality care and patient safety, and quality improvement ➢ Promote frank conversation between staff and providers regarding their experience and knowledge of an incident ➢ Review incidents with the assurance that any information generated by or for the review, other than the actual facts of the incident, is legally protected from disclosure ➢ Analyze an incident and provide recommendations to the President and Chief Executive Officer, and Chief of Staff to improve processes and prevent recurrence
Report Only (Employee)	A safety incident that did not result in, but had the potential to cause, harm
Risk	Describes the probability of danger, loss or injury within the healthcare system
Root Cause Analysis (RCA)	A quality improvement tool to help individuals and organizations determine all of the contributing factors and root causes that led to an event. RCA provides strategies for developing effective recommendations and implementing actions for system improvement.
Safety	The reduction of risk of unnecessary harm to an acceptable minimum where the acceptable minimum refers to the collective current knowledge and resources available and the context in which care/service is delivered or weighed against the risk of non-treatment/provision.
Substitute Decision Maker (SDM)	A person, other than the patient, who is legally authorized to make decisions on behalf of the patient if they are incapable. The authority may be granted by the patient when capable, by a legal document such as an advance directive by legislation (i.e. Mental Health Act, Personal Directives Act) or by the courts (i.e. Court appointed guardians).

Roles and Responsibilities

The first priority following any incident is to ensure the immediate needs of the staff, or patient/client/resident, visitor, and/or family have been met.

All staff of the partner organizations of the HPA-OHT are expected to support the core value of safety and are responsible for taking immediate steps to mitigate the progression of harm (i.e. ensuring immediate assessment of and/or treatment for any individual who has experienced harm and mitigating hazard recurrence).

Procedures for reporting safety incidents will vary according to the respective organization's system of reporting. The basic roles and responsibilities are:

- All employees, providers, students and volunteers:
    - will be familiar with the procedures for reporting occupational accidents, exposures, incidents, hazardous conditions and near misses.
    - have the responsibility to initiate the incident reporting sequence by informing their immediate supervisor in the event of an actual or potential injury or illness as soon as possible after the incident has occurred and
    - complete a report regarding the incident and/ or hazard
- The Joint Health & Safety Committee or Health and Safety representative:
    - will review and investigate specific safety incidents as indicated and
    - will initiate/plan appropriate corrective action where necessary within one week or immediately if needed.
    - will maintain the completed report, investigation, plan and action, post in the JHSC minutes, and report to Ministry of Labour/WSIB/Board of Directors as required.

HPA-OHT Accreditation organizations will include an organization-specific addendum to the harmonized policy to address their respective processes.