COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

DIAGNOSTIC ACCREDITATION PROGRAM

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POLICY

Patient Safety Incidents Reporting

Purpose

In health care, patient safety incidents that impact the lives of patients and families, as well as providers and organizations, can and do occur. In recent years, considerable focus on patient safety has been aimed at different levels: the culture of patient safety within health organizations; the knowledge associated with patient safety (methods and research); analysis of safety incidents (with resulting learning and improvements); and sharing and communicating this information with others.

The Diagnostic Accreditation Program (DAP) Committee recognizes that patient safety incident reviews can provide a positive outcome to assist medical directors and the medical team in understanding what happened and what improvements can be made to reduce the risk of similar harm to other patients in the future.

Policy

In accordance with section 13-64 of the College of Physicians and Surgeons of BC (CPSBC) Bylaws, the medical director of an independent facility must report, investigate and manage patient safety incidents in accordance with the *Patient Safety Incident Management* standard.

This policy applies to DAP independent facilities.

The medical director must provide written notice to the DAP Committee for the following patient safety incidents.

Additional information and documentation may be requested.

Critical incidents

Email notification to dap@cpsbc.ca of the event occurrence (anonymized) is required within one business day of becoming aware of any critical incident. Following an incident investigation and analysis, the Patient Safety Incident Report form must be submitted within 30 business days.

- Death of a patient, and/or any other person accompanying the patient while they are in the facility
- Incorrect results or significantly delayed or inadequate reporting which results in patient harm or death
- Multiple cases of falls resulting in patient harm or death

- Multiple infectious events which have more than one case occurring following care on the same day
- Significant laboratory error that necessitates the correction or amendment of multiple related laboratory reports.
- Error in "D" typing patient to determine requirement of RhiG
- Administration of incorrect blood products (i.e. RhiG)
- Loss or theft of a controlled drug or substance

High risk incidents

Notification is required through the submission of the Patient Safety Incident Report form within 30 business days of becoming aware of any of the incidents listed below:

- Wrong service provided resulting in patient harm
- Medication error (including radioisotope dose errors)
- Incidents arising from improper medical device reprocessing (e.g. positive biological indicator, sterilization parameter error, unsterile items used in error)
- Harm to an implanted or onplanted (i.e. superficial) medical device
- A magnet entrapment accident including near misses (nonconditional device entering zone IV or conditional device beyond its allowed field strength)
- Loss of irretrievable diagnostic materials (e.g. CSF, biopsies, images, data etc.), this includes physical loss of materials or delays in diagnostic procedures resulting in a lost ability to perform analysis
- Massive loss of samples (TDG emergency, loss of storage of untested samples that require massive recall)

The medical director must maintain a written log of all patient safety incidents requiring mandatory reporting that includes:

- the name of the patient
- the licensee(s) who performed the procedure
- the date of the incident
- the nature of the incident
- the outcome

Definitions

patient safety incident	An event or circumstance which could have resulted, or did result, in unnecessary harm to a patient.
harmful incident	A patient safety incident that resulted in harm to the patient.
no harm incident	A patient safety incident that reached a patient, but with no discernible resulting harm.

near miss A patient safety incident that did not reach the patient.

Responsibility

Role	Responsibility
Medical director	• Report, investigate and manage patient safety incidents • Submit reports on forms approved by the committee
Quality improvement lead	• Review report forms • Consult with experts as required • Initiate a PSI review as required • Provide support/education to facilities in patient safety incident reporting and review
DAP Committee	• Review severity and frequency trends for learning opportunities at a systems level

Report form

The Patient Safety Incident Report form will be available on the CPSBC website when this policy takes effect on November 1, 2026.