Non-hospital Medical and Surgical Facilities Accreditation Program

ACCREDITATION STANDARDS

Patient Safety and Incident Management

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Introduction

Ensuring patient safety is a fundamental responsibility of all health-care organizations. Despite best efforts, adverse events and near misses can occur within even the most robust systems. The way these incidents are reviewed and learned from is a key determinant of an organization's ability to prevent recurrence, improve quality of care, and maintain public trust.

This accreditation standard establishes the expectations and minimum requirements for patient safety incident management. By shifting the focus from individual blame to system learning, a culture of openness, accountability, and continuous improvement is developed.

Patient safety incident management

No.		Description	Reference	Risk	Change	Asmt.
PSMI1.0		**PATIENT SAFETY INCIDENT MANAGEMENT STANDARD**				
PSIM1.1		**The organization has a patient safety incident management process in place to effectively respond to and analyze incidents with the aim of improving quality and safety.**				
		BEFORE THE INCIDENT				
PSIM1.1.1	**M**	There is a regulated health professional responsible for overseeing the patient safety incident management process. Guidance: The person responsible for overseeing the program will depend on the size, scope and complexity of the facility and should be a person in an operational leadership role. This role/responsibility is identified on the organizational chart. In facilities where the only regulated health professional is the medical director, then the medical director is responsible.	1	M	New	P, F
PSIM1.1.2	**M**	There is an incident management plan. Guidance: The incident management plan provides an incident decision tree, model or framework to determine when a system review or an administrative review is appropriate, outlines the methods of analysis including how to select the appropriate method to analyze an incident, describes the steps and responsibilities for who is doing what, how and when, the resources available to manage the incident including policies, procedures, checklists and skills and the expected timeline for completing each step of the incident management.	2, 3, 4	M	New	P, F

No.		Description	Reference	Risk	Change	Asmt.
PSIM1.1.3	**M**	The incident management plan includes adoption of an incident decision tree, model or framework to determine when a system-based incident analysis is appropriate. Guidance: The following are some examples of organizations with patient safety management and incident analysis publications that include decision trees or approaches for determining when a system review versus an administrative review is appropriate: National Patient Safety Agency (UK), the Canadian Medical Protective Association and the Healthcare Excellence Canada. An administrative review analyzes the actions and behaviours of individuals during a patient safety incident and is outside the scope of this standard.	2, 3, 5	M	New	P, F
PSIM1.1.4	**M**	The incident management plan includes the methods of analysis and how to select the appropriate method to analyze an incident. Guidance: All methods of system review analysis aim to determine what happened, how and why it happened, what can be done to prevent its recurrence, to make care safer and to share what was learned. However, the level of detail and scope of review of an incident analysis is different depending on the complexity of the incident and the severity of harm. **Comprehensive analysis:** This method of analysis is used for complicated and complex incidents which result in significant harm or where there was the risk of significant harm and "never event" incidents. **Concise analysis:** This method of analysis is used for incidents where there is no or low harm to the patient or where the risk of harm was low. The severity of the incident, probability of recurrence, complexity of factors which influenced the incident and extent of the impact of the incident are some of the factors to consider when selecting a method to analyze the incident.	2, 3	M	New	P, F

No.		Description	Reference	Risk	Change	Asmt.
PSIM1.1.5	**M**	The incident management plan includes the analysis team membership, roles and responsibilities. Guidance: The composition and number of analysis team members differ depending on the size, scope and complexity of the facility and the method of analysis necessary to effectively analyze the incident. The plan outlines the minimum number of team members for a comprehensive analysis versus a concise analysis, the expertise of these team members,(e.g., operations leader, medical director, front-line care provider, quality specialist/risk manager), the role of these team members,(e.g., interviewing those involved, gathering information, securing equipment, and the criteria for determining when more than the minimum number of analysis team members are needed, (i.e. specific expertise), multiple departments/practice areas involved). Comprehensive analysis should include staff associated with the incident and the patient and/or family as appropriate and willing.	2, 3, 6	M	New	P, F
PSIM1.1.6	**M**	The incident management plan includes steps for securing items involved in the incident as appropriate. Guidance: Items involved in an incident such as equipment, intravenous solutions, medications, packaging, labels etc., need to be secured and protected in a restricted access area for testing and review. These items are to be labeled and placed in a designated access restricted location or given to a designated person to be labeled, protected, and secured in an access restricted location.	2, 5, 7	M	New	P, F
PSIM1.1.7	**M**	The incident management plan includes a standardized patient safety incident reporting form.	3, 8	M	New	P, F

No.		Description	Reference	Risk	Change	Asmt.
PSIM1.1.8	**M**	The patient safety incident reporting form in use at the facility has been approved by the medical director. Guidance: The medical director is responsible for ensuring the patient safety incident reporting form implemented at their facility is user-friendly and provides the initial information essential for providing a preliminary understanding of what happened so that the necessary next steps in managing and analyzing the incident can be determined.	3, 8, 9	L	New	P, F
PSIM1.1.9	**M**	The incident management plan includes the expected timeline for notifying the medical director of serious patient safety incidents. Guidance: Serious patient safety incidents are defined in organizational policies and include patient safety incidents which require reporting to NHMSFAP/DAP. Medical directors should be notified within 24 hours.	5, 6	M	New	P, F
PSIM1.1.10	**M**	The incident management plan includes the expected timelines for each step of the patient safety incident analysis. Guidance: Timely reporting and analysis of a patient safety incident is essential to the quality of its analysis and management. A timeline for expected completion of the various steps of patient safety incident reporting and analysis is outlined in the plan and includes expected timelines for completing the incident reporting form, notifying the immediate clinical leadership and medical director, selecting the type of analysis, preparing for analysis, completing the analysis and communicating what was learned and the actions implemented. Established timelines for comprehensive analysis and concise analysis may be different.	2, 3, 5	M	New	P, F

No.		Description	Reference	Risk	Change	Asmt.
PSIM1.1.11	**B**	The incident management plan includes a confidentiality agreement form. Guidance: During a patient safety incident analysis, confidentiality is to be maintained at all times. It may be useful for the analysis team members to sign a confidentiality agreement prior to each analysis they participate in.	2		New	F
PSIM1.1.12	**B**	Staff receive education on patient safety incident analysis. Guidance: An education program should be implemented particularly for analysis team members such as the medical director and other leaders as insufficient expertise may affect analysis and lead to cognitive traps such as premature completion of the analysis process, overconfidence in interpretation of known information and oversimplification of what contributed to the outcome. Various online modules provide education on patient safety incident analysis and management, some of which are a free to register for such as Healthcare Excellence Canada's Patient Safety Essentials.	2, 3, 8, 9		New	F
PSIM1.1.13	**M**	The incident management plan includes support for staff involved in patient safety incidents. Guidance: The plan outlines resources available to staff following an incident such as requesting a debriefing, providing information on resources available for mental health and wellness support.	4, 5, 8	M	New	P, F
PSIM1.2		**Patient safety incident (PSI) reporting starts the internal communication of data essential to an effective analysis process.**				
		INTERNAL REPORTING				

No.		Description	Reference	Risk	Change	Asmt.
PSIM1.2.1	**M**	A PSI reporting form is completed for each patient safety incident. Guidance: The incident form provides the first formal, detailed description and summary of the incident and notes any contributing factors identifiable at that point in time. After attending to the safety and well-being of those involved, timely completion of the reporting form is essential, so important details are not lost over time.	2, 10	M	New	F
PSIM1.2.2	**M**	The PSI reporting form includes the patient's name.	2, 10	M	New	P, F
PSIM1.2.3	**M**	The PSI reporting form includes the name of the person completing the reporting form. Guidance: The PSI reporting form includes a field for the name of the person completing the reporting form. However, the person completing the form may choose to remain anonymous and leave the field blank. Depending on the circumstances and organizational culture, anonymous/confidential reporting can lead to more reporting of patient safety incidents and concerns.	8, 10	L	New	P, F
PSIM1.2.4	**M**	The PSI reporting form includes the date the form was completed.		L	New	P, F
PSIM1.2.5	**M**	The PSI reporting form includes the type of incident. Guidance: Incident types may include wrong procedure, medication error, transfer to hospital. "good catch/near miss" etc. Also refer to the Patient Safety Incidents Reporting policy.	10, 11	M	New	P, F
PSIM1.2.6	**M**	The PSI reporting form includes the date of the incident or near miss. Guidance: The date of the incident or near miss may occur following the date of the procedure performed.	2, 12	M	New	P, F

No.		Description	Reference	Risk	Change	Asmt.
PSIM1.2.7	**M**	The PSI reporting form includes the time of the incident or near miss, as applicable. Guidance: While the PSI reporting form is to include the time of the incident, when completing the form this field can be indicated as not applicable if the time of the incident is not relevant, i.e. occurred the next day.	2	L	New	P, F
PSIM1.2.8	**M**	The PSI reporting form includes the date of the procedure and/or service at the accredited facility.		M	New	P, F
PSIM1.2.9	**M**	The PSI reporting form includes the procedure performed and/or service booked for at the accredited facility. Guidance: Procedure means a medical, surgical, dental, anesthesia or diagnostic procedure and/or treatment.		L	New	P, F
PSIM1.2.10	**M**	The PSI reporting form includes a detailed description of the incident. Guidance: The detailed description should include what occurred leading up to the incident, details of the incident including location where it occurred, (i.e. in the waiting room, in the procedure room, following discharge home), and what occurred directly after the incident.	2	M	New	P, F
PSIM1.2.11	**M**	The PSI reporting form includes a detailed description of the actions taken immediately following the incident. Guidance: This includes securing items involved in the incident, as appropriate.	2	M	New	P, F
PSIM1.2.12	**M**	The PSI reporting form includes potential contributing factors to the incident.	2	M	New	P, F
PSIM1.2.13	**M**	The PSI reporting form includes the name of the leader/manager who was notified of the incident, including date and time of their notification.	2, 5	M	New	P, F

No.		Description	Reference	Risk	Change	Asmt.
PSIM1.3		**The organization has a clear and defined process for undertaking analysis of systems in response to patient safety incidents.**				
		ANALYSIS				
		Comprehensive analysis				
PSIM1.3.1	**M**	Comprehensive analysis of a patient safety incident is undertaken when the incident is **complicated, complex, resulted in significant harm** or **where there was risk of significant harm** and for **"never events."** Guidance: The severity of the incident, probability of recurrence, complexity of factors which influenced the incident and extent of the impact of the incident are some of the factors to consider when selecting a method to analyze the incident. A "near miss" incident which resulted in no harm to the patient but where the potential risk of harm to the patient was significant requires a comprehensive assessment. "Never events" are incidents which result in serious patient harm or death and can be prevented by using organizational checks and balances. **Never events include:** wrong side surgery, wrong patient surgery, wrong tissue, implants or blood products, incorrect count, improperly sterilized instruments or equipment (improperly reprocessed instruments or equipment), death or serious harm from administration of medication where a patient's allergy has been identified, death or serious harm due to administration of the wrong inhalation or insufflation gas, patient death or serious harm as a results of a pharmaceutical error, patient death or serious harm due to an accidental burn (equipment, electrical, topical agent).	2, 4, 13	H	New	F

No.		Description	Reference	Risk	Change	Asmt.
PSIM1.3.2	**M**	An analysis team is convened and is comprised of at minimum two individuals. Guidance: At minimum, the analysis team is comprised of a clinical leader who should have training in incident analysis plus another person with relevant knowledge in the subject area, discipline and/or service. A multi-disciplinary team is recommended.	2, 6, 14	M	New	F
PSIM1.3.3	**M**	Comprehensive analysis includes understanding what happened (outcome). Guidance: This involves reviewing the incident report, reviewing the health record, interviewing persons directly/indirectly involved including the patient/family as appropriate, examining items involved in the incident, e.g. equipment, medication label, training materials, practice standards and guidelines, consultation with colleagues or experts, literature review.	2, 4, 7, 8, 9, 14	H	New	F
PSIM1.3.4	**M**	Comprehensive analysis includes creating a detailed timeline of events. Guidance: The detailed timeline of events is documented in the incident analysis report or is an appendix to the analysis report. Establishing what is believed to be the sequence of events is an important activity in understanding what happened.	2, 5, 7, 8	M	New	F

No.		Description	Reference	Risk	Change	Asmt.
PSIM1.3.5	**M**	Comprehensive analysis includes determining how (process) and why (structure) the incident happened. Guidance: This involves the use of analysis tools such as diagramming, systems theory and human factors to identify contributing factors (both those that increased the risk of harm and those that reduced the risk of harm) and the relationships between and among these factors. A system performance approach is used to identify all influencing factors such as the patient (procedure/test, comorbidities, language), care team (qualifications, training, decisions and actions), task/activity (patient check-in/admission, procedure/test), work environment (setting, staffing levels), equipment (training, maintenance) and organization (culture, communication, leadership, policies and procedures). The Canadian Incident Analysis Framework Appendix G provides a set of guiding questions to assist in identification of contributing factors at various levels in the organization.	2, 4, 7, 8, 9, 14, 15	H	New	F
PSIM1.3.6	**M**	Comprehensive analysis includes summarizing the findings. Guidance: This can take the form of a list and brief description and may include diagrams and tables to help explain the findings. It outlines what the analysis found, i.e. it outlines how the incident happened.	2, 4, 7, 8, 14	M	New	F
PSIM1.3.7	**M**	Comprehensive analysis includes recommended actions. Guidance: Recommended actions address the risk identified by the analysis. The most effective solution that is reasonable or possible given the circumstances should be implemented. The hierarchy of effectiveness (low, moderate and high leverage) should be considered when making recommendations.	2, 7, 9, 14	H	New	F
		Concise analysis				

No.		Description	Reference	Risk	Change	Asmt.
PSIM1.3.8	**M**	Concise analysis of a patient safety incident is undertaken for incidents **where there is no or low harm** to the patient or where the risk of harm was low. Guidance: The severity of the incident, probability of recurrence, complexity of factors which influenced the incident and extent of the impact of the incident are some of the factors to consider when selecting a method to analyze the incident.	2, 4	H	New	F
PSIM1.3.9	**M**	Concise analysis includes understanding what happened (outcome). Guidance: This involves reviewing the incident report, reviewing the health record and gathering sufficient information to understand what happened.	2, 4, 7, 9, 14	H	New	F
PSIM1.3.10	**M**	Concise analysis includes determining how (process) and why (structure) the incident happened. Guidance: A system performance approach is used to identify contributing factors and the relationships between and among these factors such as the patient (procedure/test, comorbidities, language), care team (qualifications, training, decisions and actions), task/activity (patient check-in/admission, procedure/test), work environment (setting, staffing levels), equipment (training, maintenance) and organization (culture, communication, leadership, policies and procedures). The Canadian Incident Analysis Framework Appendix G provides a set of guiding questions to assist in identification of contributing factors at various levels in the organization.	2, 4, 7, 9, 14, 15	H	New	F
PSIM1.3.11	**M**	Concise analysis includes summarizing the findings. Guidance: This can take the form of a list and brief description and may include diagrams and tables to help explain the findings. It outlines what the analysis found, (i.e. it outlines how the incident happened).	2, 4, 7, 14	M	New	F

No.		Description	Reference	Risk	Change	Asmt.
PSIM1.3.12	**M**	Concise analysis includes recommended actions, as appropriate. Guidance: Recommended actions address the risk identified by the analysis. Concise analysis does not always result in sufficient information to develop recommended actions.	2, 7, 9, 14	H	New	F
PSIM1.4		**The analysis report provides a clear explanation of how the organization's systems and processes contributed to the patient safety incident.**				
PSIM1.4.1	**M**	The incident analysis report includes patient identification and demographic information. Guidance: Patient identification and demographic information include the patient's name, gender and/or sex assigned at birth, date of birth.	2, 12	M	New	P, F
PSIM1.4.2	**M**	The incident analysis report includes the name(s) of the individual(s) who comprise the analysis team.	2, 12	M	New	P, F
PSIM1.4.3	**M**	The incident analysis report includes the date(s) the analysis team met to review and analyze the information.	2, 12	L	New	P, F
PSIM1.4.4	**M**	The incident analysis report includes the methodology used for the analysis. Guidance: This could be a checkbox on the report form to indicate concise, comprehensive or other type of analysis, e.g. multi-patient.	2, 5, 12	M	New	P, F
PSIM1.4.5	**M**	The incident analysis report includes a brief summary of the incident.	2, 7, 12	M	New	P, F

No.		Description	Reference	Risk	Change	Asmt.
PSIM1.4.6	**M**	The incident analysis report includes the background and context of the incident. Guidance: This background provides a short explanation of the incident and what is being analyzed. It may describe conditions or outcomes and may summarize standards or organizational policies that are central to the analysis.	2, 7, 12	M	New	P, F
PSIM1.4.7	**M**	The incident analysis report includes the information reviewed to understand what happened. Guidance: This provides an overview of the information reviewed such as interviews with key people, examining equipment and reviewing documentation such as medical records and policies and procedures. The list of information is sufficiently detailed so that it can easily be cross-referenced, i.e. policy name and date, as appropriate.	2, 12	M	New	P, F
PSIM1.4.8	**M**	The incident analysis report includes a summary of findings. Guidance: This can take the form of a list and brief description and may include diagrams and tables to help explain the findings. It outlines what the analysis found, i.e. it outlines how the incident happened.	2, 7, 12, 14	M	New	P, F
PSIM1.4.9	**M**	The incident analysis report includes a list of recommended actions. Guidance: The recommended actions should be prioritized, linked to one or more of the findings and responsibility for implementation, monitoring and oversight clearly assigned.	2, 7, 9, 12	M	New	P, F
PSIM1.5		**Recommended actions are implemented and monitored to determine whether they have helped make the system safer.**				
		FOLLOW THROUGH				

No.		Description	Reference	Risk	Change	Asmt.
PSIM1.5.1	**M**	Recommended actions for improvement arising from the patient safety incident and near miss analysis are implemented and their effectiveness monitored. Guidance: Effective recommended actions address the risk associated with the finding identified during the analysis and utilize the most effective solution that is reasonable given the circumstances (i.e. high leverage vs. low leverage options for change). Adoption of the Canadian Incident Analysis Framework is recommended.	9, 14	H	New	F
PSIM1.5.2	**M**	Recommended actions for improvement are clearly assigned. Guidance: There is a tool, form or document in place which outlines the recommended action(s), the outcome measure, the frequency of monitoring, individual responsible for monitoring/oversight and the planned review date.	2, 12	H	New	F
PSIM1.6		**Sharing what was learned is the ultimate goal of patient safety incident management.**				
		CLOSE THE LOOP				
PSIM1.6.1	**M**	What was learned is shared internally. Guidance: What was learned through the analysis should be shared with those involved in the incident, leadership, and the governing body. Ways of sharing the information could include memos, staff meetings and patient safety workshops. These activities are documented.	8, 9, 13, 16	H	New	F
PSIM1.6.2	**B**	What was learned is shared externally, as appropriate. Guidance: It may be appropriate to share what was learned through the analysis with other health partners external to the organization, i.e. contracted cases.	2, 9		New	F

No.		Description	Reference	Risk	Change	Asmt.
PSIM1.6.3	**M**	Patient safety incidents are documented in a log. Guidance: The PSI mandatory reporting log includes the name of the patient, the licensee(s) who performed the procedure, the date of the incident, the nature of the incident and the outcome. The log should also include the date the PSI was reported to NHMSFAP, as appropriate.	11	M		P, F
PSIM1.6.4	**M**	Patient safety incidents and near misses requiring mandatory reporting are given a unique identifier. Guidance: The Patient Safety Incidents Reporting Policy lists the patient safety incidents requiring mandatory reporting. The unique identifier allows for easy cross-referencing to the PSI log. The format of the unique identifier should be the facility identification number, then year, then month, then the sequential event number, e.g. (NHID-2025-11-06). The sequential event number should be reset to **1** at the start of each calendar year.	11	M	New	P, F
PSIM1.6.5	**M**	Patient safety incidents and near misses requiring mandatory reporting are reported to NHMSFAP on a form approved by the NHMSFAP Committee. Guidance: The Patient Safety Incidents Reporting Policy lists the patient safety incidents requiring mandatory reporting. The organization's policy and procedures for patient safety incidents and near miss management include reference to PSI requiring mandatory reporting and the required reporting form.	11	H	Revised	P, F
PSIM1.7		**Policies and procedures contain all the information necessary for the safety of patients, staff and visitors.** Guidance: Policies and procedures ensure that activities/procedures are performed consistently and accurately by all personnel within the non-hospital facility. They are reviewed regularly and updated when needed to maintain current best practice standards.				

No.		Description	Reference	Risk	Change	Asmt.
PSIM1.7.1	**M**	There is policy and procedures for patient safety incidents and near miss management. Guidance: The policy and procedures for patient safety incident and near miss management outline the process for reporting, investigating, analyzing what happened, implementing recommended actions and monitoring their effectiveness and sharing what was learned. Adoption of the Canadian Incident Analysis Framework is recommended.	4, 9	M	Revised	P, F

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