

## 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 the following different levels:

- the culture of patient safety within health organization,
- 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 Non-Hospital Medical and Surgical Facilities Accreditation Program (NHMSFAP) Committee recognizes that patient safety incident reviews can provide a positive outcome to assist medical directors and the surgical 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 the College of Physicians and Surgeons (CPSBC) Bylaws (section 13-27), the medical director must report, investigate and manage patient safety incidents in accordance with the CPSBC *Patient Safety Incident Management* standard.

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

Additional information and documentation may be requested.

### Critical incidents

Email notification ([nhmsfap@cpsbc.ca](mailto:nhmsfap@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 for the following:

1. Death which occurred during or within 28 days of a procedure in the facility.
2. Unexpected admission to hospital for a significant complication, except localized hematoma, within 28 days after a procedure in a facility.

3. Cluster of infections (more than one occurring on the same day, consecutive surgical cases, consecutive surgical days, same type of surgery).
4. Surgery on the wrong body part or wrong patient or conducting the wrong surgery.
5. 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:

1. A change in the type or site of surgery, (including incorrect implant/prostheses implanted).
2. Any unplanned return to the operating room.
3. Any unplanned surgery arising as a complication of the planned procedure.
4. Any surgical procedure greater than six hours (skin-to-skin time) excluding complex aesthetic face and neck surgery.
5. Incorrect count (possible retained surgical item).
6. Medication error (including surgical prep solution error).
7. Any patient required to stay in a facility for more than 24 hours following a procedure.
8. Any infection requiring:
  - a. hospitalization (admission as an in-patient)
  - b. a second surgical procedure which occurs as a result of the procedure other than simple incision and drainage
  - c. ongoing outpatient IV therapy > 72 hours
9. Any occurrence of VTE arising within 28 days of a procedure in a facility.
10. Any patient requiring a blood transfusion within 28 days of a procedure in a facility.
11. Medical device reprocessing error (e.g. positive biological indicator, sterilization parameter error, unsterile items used in error).
12. Near miss that could have resulted in a critical or high risk incident (an occurrence that could have resulted in an accident, injury, or illness but did not by chance, skillful management, or timely intervention).

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

<b>patient safety incident</b>	An event or circumstance which could have resulted, or did result, in unnecessary harm to a patient.
<b>harmful incident</b>	A patient safety incident that resulted in harm to the patient.
<b>no harm incident</b>	A patient safety incident that reached a patient, but with no discernible resulting harm.
<b>near miss</b>	A patient safety incident that did not reach the patient.

## Responsibility

Role	Responsibility
Medical director	<ul style="list-style-type: none"> <li>Report, investigate and manage patient safety incidents</li> <li>Submit reports on forms approved by the committee</li> </ul>
Quality improvement lead	<ul style="list-style-type: none"> <li>Review report forms</li> <li>Consult with experts as required</li> <li>Initiate a PSI review as required</li> <li>Provide support/education to facilities in patient safety incident reporting and review</li> </ul>
NHMSFAP Committee	<ul style="list-style-type: none"> <li>Review severity and frequency trends for learning opportunities at a systems level</li> </ul>

## Reportable incident form

The Patient Safety Incident Report Form is available on the CPSBC website.