AK0400 GUIDELINE 1.1: IMMEDIATE MANAGEMENT OF ADVERSE EVENTS
ENDORSEMENT DATE: FEBRUARY 2022

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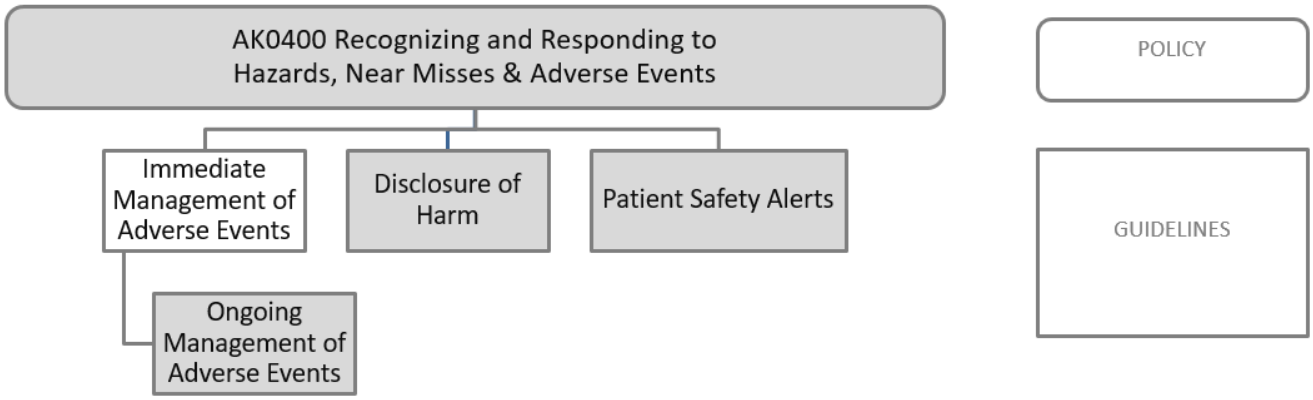
The ***OFFICIAL*** version is available on the InsideNet.

DEFINITIONS

Accountable leader	The individual who has ultimate accountability to ensure the consideration and completion of the listed steps in the AK0400 Guideline 1.2 IH Ongoing Management of Adverse Events. The accountable leader may delegate responsibility for some or all of the components of management to others, but the accountability remains with the accountable leader.
Adverse event (AE)	An unexpected and undesired event which results in an unintended consequence and is directly associated with the care or services provided to the patient rather than the patient's underlying condition.
Apology	An expression of sympathy or regret, preferably using the words "I'm/we're sorry". An apology is not necessarily an admission of error.
Circle of Care	A group of internal and external healthcare providers supporting a specific person, with whom personal information is shared based on an implied consent model, for the purpose of contributing to their health care plan and meeting the service needs for them and their family.
Clinical leader	The most senior leader immediately available to manage an adverse event. This may be a charge nurse, on-duty supervisor, administrator on call, most responsible practitioner, unit manager, Quality Review Coordinator or other leader as appropriate.
Critical incident	An adverse event that results in severe physical or psychological harm or death.
Decision Review Team	Brought together by the accountable leader with support from Patient Safety and Risk Management, a Decision Review Team includes operational leaders, medical staff and network leaders who review a serious adverse event and collectively make decisions regarding next steps and the need for further review.
Disclosure	The imparting of information to a patient and/or family pertaining to harm.
Family	One or more individuals identified by the patient as an important support, and who the patient wishes to be included in any encounters with the health care system, including, but not limited to, family members, legal guardians, friends and informal caregivers. For patients unable to express their wishes, family would include those we can share health information with as per established consent processes.
Handler	The Handler designated in the PSLS report is responsible for ensuring the event is investigated appropriately and that necessary actions are taken. During the Immediate Management phase of an adverse event, the Handler would be the clinical leader. During the Ongoing Management phase of an adverse event, the Handler would be the accountable leader.
Harm	An unexpected and undesired outcome for the patient that negatively affects the patient's physical, psychological (mental or emotional) health and/or quality of life. The PSLS defines degrees of harm as: 1 – No harm 2 – Minor harm 3 – Moderate harm 4 – Severe harm 5 – Death
Hazard	A circumstance, agent or action with the potential to cause harm.
Most Responsible	The Most Responsible Practitioner is the Physician, Nurse Practitioner, Oral

Practitioner (MRP)	Surgeon or Midwife whose name appears in the patient's chart designated as the MRP and who has overall responsibility for directing and coordinating the medical care and management of an individual patient, resident or client.
Near miss	An event with the potential for harm that did not result in harm because it did not reach the patient due to timely intervention or good fortune (sometimes called a close call or good catch).
Never Event	Adverse events that may result in serious patient harm or death and that are preventable using organizational checks and balances.
Patient	Includes all clients, residents, service users and persons in care in Interior Health facilities and programs. In this policy and associated guidelines, references to the patient will include the family if the patient wishes.
Patient Safety Learning System (PSLS)	BC Patient Safety Learning System (PSLS) is a web-based tool used by health-care professionals across B.C. to report and learn from adverse events, near misses and hazards that occur in health care settings.
Person & Family Centered Care	A Person & Family Centered Care approach puts patients at the forefront of their health and care, ensures they retain control over their own choices, helps them make informed decisions and supports a partnership between individuals, families and health care service providers.
Second harm	Negative effects on health and well-being resulting from the impact of being involved, witnessing or affected by an adverse event. Family members of patients, care providers and others may be affected.
Trauma-Informed Practice	A strengths-based framework grounded in an understanding of and responsiveness to the impact of trauma. It emphasizes physical, psychological and emotional safety for everyone, and creates opportunities for survivors to rebuild a sense of control and empowerment.

Overview of AK0400 Recognizing and Responding to Hazards, Near Misses & Adverse Events



PRINCIPLES

Person & Family Centered Care: We believe in a collaborative approach to safety that includes engagement with patients, their families (if family involvement is aligned with patient wishes), and others who have been involved or affected by Adverse Events (AEs). We will work to ensure they are treated with dignity, respect, compassion and empathy using a trauma-informed and culturally safe approach to support healing and rebuild trust with Interior Health. Information sharing, participation and collaboration with patients and families will occur to the greatest extent possible throughout this process in keeping with applicable privacy and legislation. Patients are entitled to the facts about the care they receive.

Just Culture: Interior Health promotes a 'just culture' in which transparency, fairness, accountability and

a focus on learning and improvement from AEs are key elements. We support all people with empathy and support following an AE. We avoid speculation or making assumptions that a poor clinical outcome is the result of error or poor judgment – a review needs to take place before any assignment of accountability might occur.

Our People: We recognize that health-care providers may also be harmed when an AE occurs. When patients in their care are harmed, health-care providers may suffer from professional and personal anguish. We will support and treat employees and medical staff with care, dignity, respect, compassion and empathy in keeping with the principles of a Just Culture.

Patient Safety: Health-care providers aim to minimize risks to patient's physical and psychological well-being. Patients, employees, medical staff and the public should not be exposed to harm where it is reasonably avoidable. Health-care providers, to the extent they have control, and health systems are accountable for the quality of patient care provided.

We strive to create an environment where everyone feels safe, encouraged and enabled to report and discuss safety concerns. We recognize the potential for hindsight bias (the perception following an event that it was more predictable than it actually was) and outcome bias (we evaluate actions impartially in consideration of the circumstances and context of what occurred, rather than based on results and outcomes). We avoid the temptation to reduce complex issues to simple individual human error.

Learning: We recognize that understanding and learning from AEs is essential to improving patient safety. This is accomplished respectfully with the utmost sensitivity, empathy and compassion for all involved.

1.0 GUIDELINE

1:10 Key Points

1.11 When any IH employee or medical staff member recognizes an adverse event (AE) has occurred, or when a patient and/or family member brings it to their attention, they must report it to a clinical leader.

1.12 The clinical leader may be a charge nurse, on-duty supervisor, facility or unit manager, administrator on call, Most Responsible Practitioner (MRP) or other leader (e.g. network, program) as determined by the circumstances. The clinical leader will be mutually agreed upon by those immediately available to assume the responsibilities of the role.

In deciding who the clinical leader shall be, consider an individual:

- Who is immediately available at the location of the AE;
- Who is the most senior/experienced leader available;
- Who, if possible, has a pre-existing relationship with the patient and/or family; and
- With consideration for patient preference if applicable and possible.

1.13 The clinical leader will assess the facts to determine the required next steps. It is important to evaluate the AE through a systems lens in the context of the situation and circumstances in which it occurred and the reasoning for individuals' actions at the time.

1.14 The duties of the clinical leader may be turned over to subsequent clinical leaders as needed (e.g. at shift changes or transitions in care) and briefing of a new clinical leader shall occur. If handover occurs, consider appointing a single point of contact to provide continuity for communication with the patient or family.

1.15 Immediate management of an AE shall be started as soon as it is identified and be completed

as soon as feasible, ideally within 24 to 48 hours. Complex events (i.e. involving more than one department, area of care, facility, provider) may take longer to complete.

1.16 If needed, the clinical leader may consider requesting support from others for the immediate management of the event, such as the accountable leader or IH Patient Safety. The Patient Safety page on InsideNet has resources and tools to assist with this guideline.

1.17 Immediate management of an AE can be concluded when ALL of the following criteria are met:

- The outcome of an AE for the patient and providers did not cause severe physical/psychological harm or death,
- The AE does not meet the definition of a Never Event (Appendix A), and
- The clinical leader determines there is no need for further investigation.

If any of the above criteria are not met, the clinical leader shall ensure a handover occurs to the accountable leader for ongoing management. Unresolved concerns from the patient/family member may also require ongoing management (e.g. further disclosure conversations, complaint escalation process).

Handover to the accountable leader can occur immediately if appropriate. See AK0400 Guideline 1.2 Ongoing Management of Adverse Events.

Note: The order of the steps below is recommended; the actual order of the steps must reflect the needs of each situation and may be done concurrently.

1.20 Physical and Psychological Support for Patients & Families

Use a trauma-informed approach to assess the needs of the patient and family members. The clinical leader will ensure the following occurs as required:

1.21 The physical/medical needs of the patient and/or family are being attended to. This may include additional diagnostics or treatment, medical care or changes to the care plan.

1.22 The psychological (i.e. mental, emotional) needs of the patient and/or family are being attended to. This may include spiritual and emotional support. Provide assistance with finding a spiritual leader, Elder or member of a faith or cultural community as needed.

1.23 Determine whether any additional patients have been or have the potential to be affected by the AE and ensure all possible steps are taken to prevent further harm.

1.24 If there has been harm, begin the apology and acknowledgement portion of the disclosure process in accordance with AK0400 1.3 Guideline Disclosure of Harm.

1.25 If feasible, discuss with the patient if they wish to have their care transferred to other health-care professionals and/or medical staff. If so, facilitate as soon as possible.

1.26 Provide immediate practical support (e.g. translation services, access to a telephone, parking arrangements for family, privacy, a quiet space for communication to occur). Appoint a contact person for continuity of patient/family communication as appropriate.

1.30 Physical and Psychological Support for Employees and Medical Staff

The clinical leader shall ensure the following occurs as appropriate:

1.31 Arrange for immediate first aid for any employees and/or medical staff if required. Report workplace hazards, physical or psychological injuries and/or accidents to Workplace Health Call

Centre 1-866-922-9464 as per AV1100 Employee Incident Reporting and Investigation.

1.32 Assess the needs of the employees and medical staff involved in the event and transfer patient care to alternate providers if necessary.

a. If employees are temporarily unable to continue to provide safe patient care, they will be supported to stop working and every reasonable attempt made to arrange for alternate staffing. If medical staff are unable to continue to provide safe patient care, they will work with their medical administrative leader and/or colleagues to determine appropriate coverage as soon as it is safe and feasible to do so, as per the processes outlined in the IH Medical Staff Bylaws s.5.2.

b. Use a trauma-informed approach to assess the needs of all impacted employees and medical staff, including but not limited to:

i. Others who may have interacted with the patient including volunteers, students, family members and non-health-care professionals;
ii. Employees and medical staff from other units, clinical areas or programs who have been involved directly or indirectly with the patient; and
iii. Any affected leaders.

1.33 Offer trauma-informed support to the employees and medical staff to promote psychological health as per AV3000 Psychological Health & Safety in the Workplace.

a. When possible, arrange a quiet and private place for all communication and documentation to occur.

b. Provide emotional support to assist in coping with the AE.

c. Provide information about, and referral to, support programs and encourage staff and medical staff to seek assistance, including but not limited to:

i. Employee physical and psychological wellness resources on InsideNet,
ii. The Employee and Family Assistance Program,
iii. The Physician Health Program, and
iv. The WorkSafeBC Critical Incident Response Program.

d. Arrange for and cover cost of transportation home (e.g. taxi voucher) if staff feel they are unsafe to drive or do not have transportation available when leaving the workplace.

e. Follow up and check in with staff 24 to 48 hours after the event, expressing concern for their well-being, and refer to support programs if needed.

1.40 Environmental Safety for Patients, Visitors, Volunteers, Employees and Medical Staff

The clinical leader shall ensure the following occurs as appropriate:

1.41 Maintain or create a safe environment free from hazards. Ensure the area is safe for everyone before allowing anyone to return.

1.42 If the patient is deceased, leave all medical devices, medication, clothing and/or invasive items (e.g. lines, tubes) with the deceased until removal is approved or directed by the Coroner.

1.43 If medical devices are involved in, or suspected of contributing to, an AE:

a. Preserve evidence by not changing settings or disconnecting parts unless required. In the case of a serious AE, consider photographing equipment in place prior to quarantining. Preserve peripheral equipment (i.e. tubing, adapters, etc.).

b. Label the involved devices. Cover equipment with plastic if soiled and ensure it is labeled appropriately so it is not used until deemed safe for use by Biomedical Engineering.

c. Ensure reporting of medical device problems through PSLS and contact your local Biomedical Engineering department immediately via Web Request or by phone for urgent requests.

d. Establish a secure chain of evidence by storing the used devices securely until next steps have been determined. If there was harm, do not release devices or information to the vendor until authorized by the appropriate department.

1.50 Disclosure

For all AEs, the clinical leader shall assess the need for disclosure and ensure it occurs.

Assess whether the AE meets the IH threshold for disclosure and follow appropriate steps as per AK0400 Guideline 1.3 Disclosure of Harm.

1.60 Documentation

For all AEs, the clinical leader shall ensure the following occurs:

1.61 The AE is documented in the health record as per the IH Clinical Documentation Standards, and shall include:

a. Relevant clinical facts related to the AE,
b. Any revisions to the patient care plan as a result of the AE,
c. Notification(s) of others of an AE (e.g. MRP, supervisor, accountable leader), and
d. The facts of disclosure conversations that have occurred (see AK0400 Guideline 1.3 Disclosure of Harm).

Speculation and opinions about the AE should not be included in the health record. Indicating that a PSLS report was made should not be included in the health record as it is separate from the legal requirement to document patient care in health records.

1.62 All IH employees and medical staff have a responsibility to voluntarily report hazards, near misses and AEs for the purpose of learning about and improving the safety in the Patient Safety Learning System (PSLS). IH is committed to fostering a just culture that includes reporting and learning as a key element. This means that reporting is conducted within a psychologically safe environment where human fallibility is acknowledged.

1.63 The clinical leader becomes the PSLS Handler of the event, records follow-up activities, assigns actions and closes the event when completed.

Documenting in the PSLS does not replace the obligation for employees and medical staff to document information relating to patient care in the health record. When the PSLS is not available, the PSLS Outage Form can be used.

1.64 There is additional mandatory reporting or processes to follow for AEs that meet specific criteria. The clinical leader shall review the following questions to determine if an event may require

reporting to external organizations:

a. Was there inappropriate or unprofessional conduct, or do you have serious concerns about the clinical care provided by a health-care professional?
b. Was there abuse against a patient by an IH employee or medical staff member?
c. Do you have reason to believe a child was abused or needs protection?
d. Did the event cause harm to more than one patient?
e. Did the event involve an adverse reaction to a transfusion of blood components or products?

The clinical leader may hand over to an accountable leader for management if any of these criteria are met.

1.70 Notification/Handover

1.71 The clinical leader will notify employees and medical staff who were directly involved in the event (if not already aware), the MRP and the supervisor or manager for the area (if applicable) within 24 hours of becoming aware of the AE.

1.72 If the criteria in section 1.17 are not met, the clinical leader shall ensure that handover of the AE management is done with the accountable leader who will be handling ongoing management of the serious AE (see AK0400 Guideline 1.2 Ongoing Management of Adverse Events). The accountable leader will then be assigned as Handler in the PSLS.

When the event involves an outcome of serious harm or death, and/or is considered a Never Event (see Appendix A), the clinical leader should consult with IH Patient Safety as soon as possible. Patient Safety may directly notify the Vice President, Medicine & Quality, and the President & Chief Executive Officer for their awareness. This would be in addition to other notifications made by the clinical or accountable leader.

2.0 REFERENCES

N/A

3.0 DEVELOPED BY

Director, Patient Safety

4.0 REVISED BY

N/A

5.0 REVIEWED BY

N/A

6.0 ENDORSED BY

Health Authority Medical Advisory Committee October 2021
Quality Management Committee December 2021
Senior Executive Team February 2022

Please provide a list of keywords to aid in searching for this tool:

Harm; Safety; Disclosure; Incident; Critical; Adverse Event; Hazard; Near Miss; Immediate; Management

Appendix A Never Events

Never events are AEs that may result in serious patient harm or death and that are preventable using organizational checks and balances. Never events are not intended to reflect judgment or blame or provide a guarantee; rather, they represent a call-to-action to prevent their occurrence. While the PSLS is a voluntary reporting system, staff and physicians are strongly encouraged to report any never events they may become aware of in the PSLS.

Additional explanation to help determine whether an AE is considered a Never Event is available in the Never Events for Hospital Care in Canada document.

1. Surgery on the wrong body part or the wrong patient, or conducting the wrong procedure.
2. Wrong tissue, biological implant or blood product given to a patient.
3. Unintended foreign object left in a patient following a procedure.
4. Patient death or serious harm arising from the use of improperly sterilized instruments or equipment provided by the health-care facility.
5. Patient death or serious harm due to a failure to inquire whether a patient has a known allergy to medication, or due to administration of a medication where a patient's allergy had been identified.
6. Patient death or serious harm due to the administration of the wrong inhalation or insufflation gas.
7. Patient death or serious harm as a result of one of five pharmaceutical events.
   The following five pharmaceutical events represent errors that can result in serious consequences for patients:
   - Wrong-route administration of chemotherapy agents, such as vincristine administered intrathecally (injected into the spinal canal).
   - Intravenous administration of a concentrated potassium solution.
   - Inadvertent injection of epinephrine intended for topical use.
   - Overdose of Hydromorphone by administration of a higher-concentration solution than intended (e.g. 10 times the dosage by drawing from a 10 mg/mL solution instead of a 1 mg/mL solution, or not accounting for needed dilution/ dosage adjustment).
   - Neuromuscular blockade without sedation, airway control and ventilation capability.
8. Patient death or serious harm as a result of failure to identify and treat metabolic disturbances.
9. Any stage III or stage IV pressure ulcer acquired after admission to hospital.
10. Patient death or serious harm due to uncontrolled movement of a ferromagnetic object in an MRI area.
11. Patient death or serious harm due to an accidental burn.
12. Patient under the highest level of observation leaves a secured facility or ward without the knowledge of staff.
13. Patient suicide, or attempted suicide that resulted in serious harm, in instances where suicide prevention protocols were to be applied to patients under the highest level of observation.
14. Infant abducted, or discharged to the wrong person.
15. Patient death or serious harm as a result of transport of a frail patient, or patient with dementia, where protocols were not followed to ensure the patient was left in a safe environment.