



AK0400 - INCIDENT MANAGEMENT

(Employee incidents are reported and investigated as per Policy [AV1100 – Employee Incident Reporting and Investigation.](#))

1.0 PURPOSE

To continually improve the quality of health service delivery in Interior Health by identifying, reviewing, and preventing untoward incidents related to delivery of care/service.

To ensure incident investigations are timely and follow consistent processes.

To establish accountabilities for managing, reporting, investigating and following up incidents.

To ensure incident management is based on evaluation and improvement in structure, process, and systems for the purposes of improving quality and safety, thereby reducing risks to Patients, providers and the organization.

2.0 DEFINITIONS

Good Catch (near miss, close call):	An event that could have caused harm but was caught before reaching the Patient.
Disclosure:	The imparting of information to a Patient pertaining to an Adverse Event and/or a Good Catch (near miss, close call) affecting or liable to affect the Patient's interest.
Incident:	Any untoward or Adverse condition or Event that deviates from normal operational routine or results in unexpected outcomes. The degree of harm (incident severity) will be rated as follows: 0 - Good Catch (near miss, close call), 1 - No Harm, 2 - Minor Harm, 3 - Moderate Harm, 4 - Severe Harm, or 5 - Death. Note: for the purpose of this policy <i>INCIDENT</i> does not include staff safety "incident".
Interior Health Staff:	Includes all IH employees, medical staff, students, volunteers that provide services on behalf of Interior Health.
Most Responsible Practitioner (MRP):	The practitioner who has accepted the overall responsibility for the management and coordination of care of the Patient at any given time.
Patient:	Includes all clients, residents and persons in care in Interior Health (IH) facilities and programs.
Contracted Partner:	Approved contractor of a health authority who plans and delivers publicly subsidized services directly to clients.

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3.0 POLICY

3.1 Incident Reporting

Incident reports are initiated by the person involved in or discovering the incident as close to the time of the event as possible.

A comprehensive incident management system is maintained and includes:

- reporting,
- analysis,
- investigation,
- tracking and quality improvement, and
- follow-up for audit of changes and/or recommendations.

All incidents should be documented in the [Patient Safety Learning System \(PSLS\)](#).

When the PSLS system is not available, use of the [BC PSLS Outage Form](#) is required.

While the PSLS is a voluntary reporting system, it is strongly encouraged that Never Events (Appendix D) are consistently reported in the Patient Safety Learning System (PSLS).

Note: Some programs may require specific incident reporting forms, (e.g. BC Centre for Disease Control, Contracted Partners to IH Licensing).

Staff safety incidents are reported as per Policy [AV1100 – Employee Incident Reporting and Investigation](#).

All events resulting in severe harm or death must be reported by the Director of Risk Management (or delegate) to the Minister of Health per the Hospital Act Regulation using the Provincial Protocol for the Management of Adverse Events.

3.2 Support for Health Care Staff

Interior Health is committed to promoting a “Just Culture” of safety in which its health care providers can readily report Incidents in order to learn and work to improve the safety of patient care. Following an incident involving patient care Interior Health commits to:

- a) Providing appropriate care and support for Patients, families and healthcare providers involved.
 - i. Employees can access the [Employee and Family Assistance Program](#).
 - ii. Physicians/trainees and their family/dependents can access the [Physician Health Program](#).
 - iii. For all employees and physicians/residents involved in a Critical Incident at/during work are covered via [Critical Incident Response Program](#) through WorkSafe BC free of charge.
- b) Evaluating all factors that may have contributed to the event using appropriate investigative techniques.
- c) Following established and fair processes for evaluating actions and behaviors of healthcare providers.

3.3 Disclosure

See Policy [AH0400 - Disclosure of Adverse Incidents](#).

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3.4 Follow Up - Learning and Informing

Quality Risk & Accreditation Department staff will support IH Staff to follow up and learn from incidents.

Interior Health is committed to communicating open, honest and timely information to the Patients, IH Staff and Board about:

- a) incidents which did or may have affected Patients, and
- b) important system improvements arising from quality and critical incident reviews.

Incident review and follow up process should be documented within the BCPSLS Events module. This ensures a standard approach to documentation and transparency of incident investigation, recommendations, and audit in one location. Documents protected under s.51 of the BC Evidence Act should not be attached within this module.

Some types of incidents (critical incidents) will require a more rigorous level of review and analysis. These include incidents rated at a degree of harm of 4 or 5 and others which may be identified from time to time by the Senior Executive Team as warranting closer review. The review of critical incidents will include events occurring at our Contracted Partners. This is not meant to interfere or impede the statutory responsibility of the Medical Health Officer to investigate reportable incidents as defined in the Residential Care Regulations or elsewhere (see Appendix E - Critical Incident Review Process: Teams, Roles, and Responsibilities)

Some incidents will require that immediate action be taken to ensure the safety of Patients, staff and the public. Policy [AK0500 Safety Alerts and Broadcasting System](#) provides direction to distribute and take action on immediate hazards that may be identified.

Interior Health will communicate transparently in situations where events have affected or have the potential to affect confidence in the care and services provided by Interior Health.

Interior Health will foster a culture of sharing information about patient safety which will lead to further system improvements.

3.5 Confidentiality

All activities and documentation relating to incident reports and reviews are considered confidential and available only to authorized individuals. Interior Health will maintain the confidentiality of the information provided, apart from its strict use as a tool to manage risks and improve quality. Release of information is governed by appropriate legislation.

4.0 PROCEDURES

Degree of Harm - Appendix A

Patient/Visitor Incident - Appendix B

Critical Incident Checklist - Appendix C

Never Events - Appendix D

Critical Incident Review Process: Teams, Roles, and Responsibilities - Appendix E

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5.0 REFERENCES

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 - Just and Trusting Culture of Safety
 - Reporting Harm, Close Calls and Hazards
 - Disclosing Harm to Patients
 - Informing Principal Health Partners & Stakeholders about Safety Hazards, Failures, Fixes
2. Management of Critical Incidents (draft) Fraser Health Authority 2006
3. Provincial Health Services – Policy 2007 Commitment to a Culture of Patient Safety
4. Winnipeg Regional Health Authority Critical Incident Management and Learning Policy June 2007
5. BC Patient Safety Learning System (BC-PSLS 2007)
6. BC Patient Safety Task Force, Disclosure Policy Guidance Document
7. Just culture of safety: How to report and participate in reviews of adverse events, The Canadian Medical Protective Association, March 2010
8. Canadian Incident Analysis Framework – cpsi, ismp, Saskatchewan Ministry of Health 2012
9. Order in Council 410 – British Columbia Ministry of Health September 26, 2013
10. Incident Decision Tree – Dr. James Reason - National Health Service (UK)
11. Canadian Council on Healthcare Accreditation CCHSA, 2003
12. Section 51 of the BC Evidence Act
13. Adult Care Regulations – CC and Assisted Living Act. BC Reg. 278/Sept 2005
14. Institute of Medicine’s 1999 report *To Err is Human: Building a Safer Health System*
15. The McGill University Health Centre Policy on Sentinel Incidents: Using a Standardized Framework to Manage Sentinel Incidents, Facilitate Learning and Improve Patient Safety , Mark Daly , Healthcare Quarterly, 9(Sp) 2006: 28-34
16. Interior Health – Board Manual – HAMAC - Medical staff rules / Terms of Reference Jan 2007
17. The Conceptual Framework for the International Classification of Patient Safety – (ICPS) World Health Organization 2007-8.
18. Interior Health AK0300 - Claims Management policy
19. Interior Health AK0400 - Disclosure of Adverse Incidents policy
20. Health Canada’s “User Problem Reporting for Medical Devices (GUI-0060) and reporting Form:
 - http://www.hc-sc.gc.ca/dhp-mps/compli-conform/prob-report-rapport/gui-0060_prob-rpt_doc-eng.php
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APPENDIX A

DEGREE OF HARM (Severity Rating)

The following table provides examples of incidents which fall under the corresponding rating and category. The lists do not contain all the incidents which may come under the specified category. Incidents which are not included in any of the following categories should be rated in consultation with the appropriate manager/designate.

Severity Rating	Degree of Harm	Description of Incident
0	GOOD CATCH (Near miss, close call)	An event that could cause harm but is caught before it reaches the Patient. Example: A nurse was about to give a medication to a Patient but realized it was the wrong medication.
1	NO HARM	An unexpected, undesired event directly associated with care or services reaches the Patient but no harm/injury occurs. Example: <ul style="list-style-type: none"> • Patient receiving codeine post op - physician discontinues order - order is not flagged for processing - nurse gives codeine instead of switching to Tylenol - extra dose - no harm. • Oximeter malfunctioning - reading 65% - Patient looks pink, in no distress - new machine applied - saturations 100% - no harm to Patient. • Patient slipped on wet floor while ambulating without assistance - regained balance without falling but jarred back causing temporary increase in soreness. Recovered quickly without any additional pain medication or intervention. No harm to Patient. • Blood ordered due to low counts. Delay in getting blood from lab due as no porters available. Delay in giving blood but no adverse effects noted. No harm to Patient.
2	MINOR HARM	An unexpected, undesired event directly associated with care or services reaches the Patient resulting in minor harm / injury. Example: <ul style="list-style-type: none"> • Patient's IV goes interstitial, red, swollen, and sore. Requires warm compresses, acetaminophen. Okay after a few hours, results in bruise. • Patient receives total enteral feed in 1 hour instead of 4 hours. Agitated, moaning, vomits. Needs extra blood work to check electrolytes. • Patient up to bathroom without assistance after epidural wears off. Falls, red area on knee, some bleeding from episiotomy incision. Physician examines, ice applied.
3	MODERATE HARM	An unexpected, undesired event directly associated with care or services reaches the Patient resulting in moderate harm/injury. Example: <ul style="list-style-type: none"> • Patient's IV goes interstitial - on pump - limb is hard, site looks burned, plastic surgery consulted, ointment and dressings applied, some scarring occurs. • Patient receives 10-fold dose of IV morphine, has respiratory arrest, requires resuscitation, is transferred to ICU and ventilated once-a-day, recovers but spends extra 2 days in hospital, family very upset. • Patient falls out of bed, complains of pain in arm - x-rays reveal fracture -

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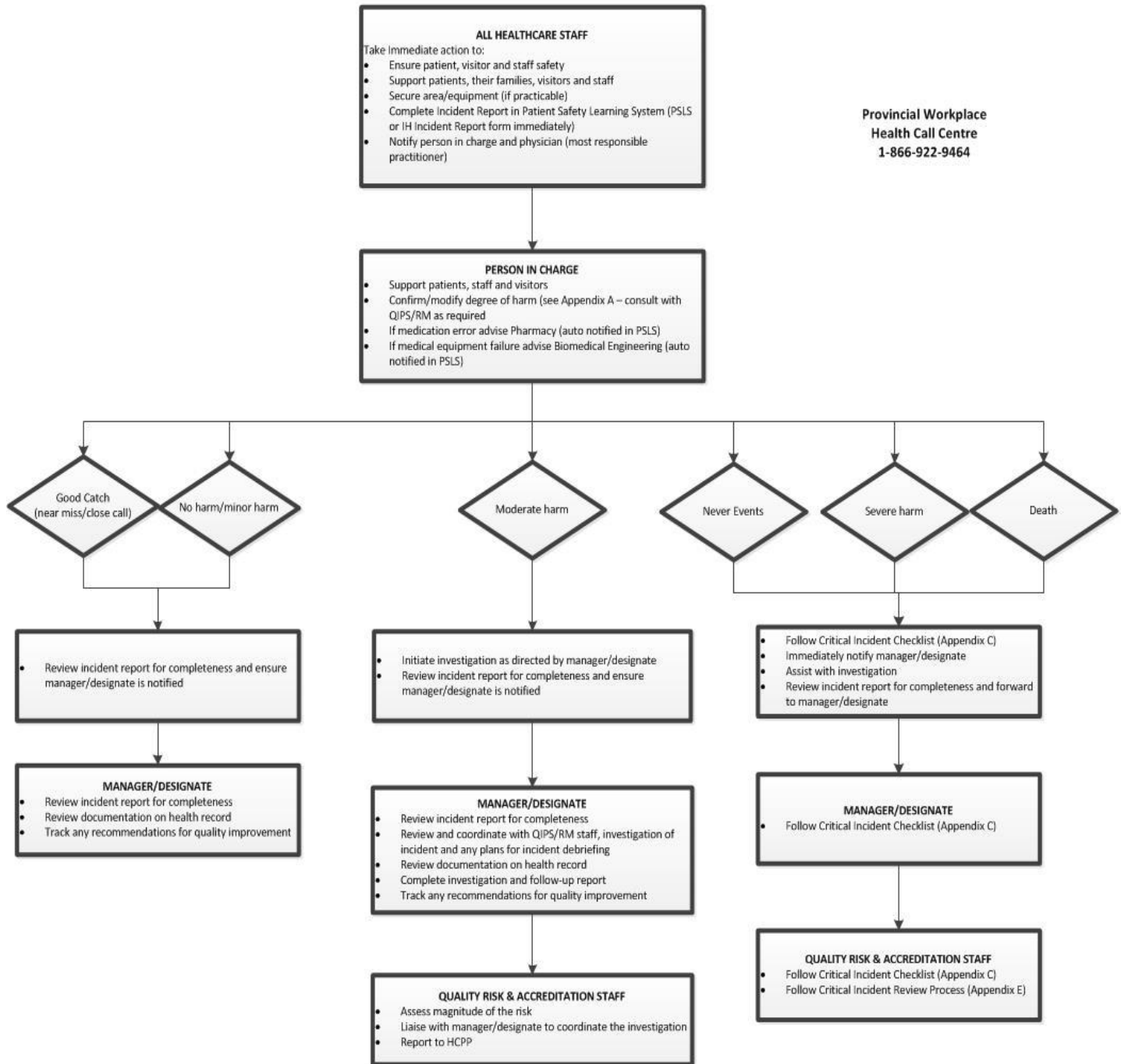
		<p>Patient spends several additional days in hospital due to pain and mobility issues - needs home care set up before discharge can occur.</p> <ul style="list-style-type: none"> • Injury or drug variance/reaction that has the potential to: a) significantly alter hospital stay or treatment plan, or b) result in admission to hospital or a higher level of care
4	SEVERE HARM	<p>An environmental emergency that impacts a health system's ability to function (e.g. a serious flood affecting a hospital or clinic), or an unexpected, undesired event directly associated with care or services reaches the Patient resulting in severe harm / injury.</p> <p>Example:</p> <ul style="list-style-type: none"> • Patient's IV goes interstitial during surgical procedure - on infusion pump - leg is grossly swollen, white, hard, pulseless - compartment syndrome diagnosed - requires emergency fasciotomy to release pressure - suffers severe pain, needs IV antibiotics, skin grafts - spends significant extra time in hospital - is left with limp and severe scarring. • Patient falls out of bed, fractures c-spine - requires surgery to fuse and repair - spends time in halo traction - in hospital for long period of time as a result - left with some permanent neurological deficits. • Wrong side surgery results in Patient's healthy kidney being removed instead of cancerous one. Cancerous kidney subsequently removed, Patient on dialysis awaiting transplant. • A resident (A) in a secure dementia unit is pushed to the floor by another dementia patient (B). Resident A is sent to hospital for assessment of their injuries which include fractured hip and various contusions and bruises. Resident A is later returned to their home facility.
5	DEATH	<p>An unexpected, undesired event directly associated with care or services reaches the Patient resulting in or significantly contributing to the Patient's death.</p> <p>Example:</p> <ul style="list-style-type: none"> • Patient is inadvertently given Hydromorphone instead of morphine resulting in a massive overdose, respiratory depression and death. • Patient's bowel is nicked during abdominal surgery - Patient succumbs to massive infection. • Patient comes to ED seeking treatment for chest pain, but does not speak English. No interpreter is available and Patient, who also has flu-like symptoms, is triaged as low priority by ED staff. Several hours later, while sitting in the waiting area collapses and dies due to massive cardiac event. • Resident A and Resident B engage in an argument in the dining room of their facility. Resident B punches Resident A and shoves them to the floor. Resident B is sent to hospital and later dies following evacuation of a subdural hematoma sustained in the shove which resulted in impact of Resident A's head to the floor.

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APPENDIX B

PATIENT/VISITOR INCIDENT

Provincial Workplace
Health Call Centre
1-866-922-9464



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APPENDIX C

CRITICAL INCIDENT CHECKLIST

For Incidents classified as severe harm (4) or death (5) or incidents classified as Never Events (Appendix D) (or other incidents of lesser severity that may be deemed critical incidents at the discretion of Senior Executive Team or the Ministry of Health).

Staff/Managers should continue to follow the Urgent Notification to SET On Call of an Emerging Issue or Event at: <http://teamsites.interiorhealth.ca/sites/Corporate/IH-AdmOnCall/Acute and Residential/Urgent Notification of SET on Call May 18 2017 v1.1.doc>

Timeline for Critical Incident

1. INITIAL RESPONSE ON UNIT (front line staff with patient care coordinator, supervisor or manager)

- Stabilize situation
- Immediately notify:
 - most responsible practitioner (MRP)
 - Site Administrator or Admin-on-Call
- Ensure staff complete an Incident Report using the Patient Safety Learning System or BC PSLs Outage Form if PSLs is not available.
- Secure scene until the immediate investigation is complete. If incident is a death, do not remove invasive items from the body (in Coroner's cases) until Coroner has authorized the removal.
- Event where there is a suspicion of criminal activity, staff should take direction from the police authority and consult Risk Management as soon as possible. Refer to Policy [AF0500 Police Designated/Delegated Authority Access to Clients and Client Information](#). This would include assault resulting in injuries that require assessment at a higher level of care. This assault can be between Patients, visitor and Patients or staff/volunteers/medical staff and Patients. Staff should consult with their immediate supervisor and escalate as necessary to determine appropriate notification to police authority.
- Secure all items relevant to the incident (e.g. medication vials, solutions, syringes, equipment). If a concern exists about any product, set aside the entire lot. If a concern exists regarding equipment, remove from service until safety is verified or Risk Management staff authorizes the equipment's use. **DO NOT SEND EQUIPMENT BACK TO THE VENDOR.**
- Discuss potential Coroner notification with MRP [any individual can notify the Coroner per the Coroner's Act Part 2 s.2.(1)]
- Document layout and description of the scene as necessary
- Record names and contact information of :
 - all personnel (includes staff, students, physicians) involved in the incident,
 - all staff on-duty in the department, in-charge person, any visitors present at the scene

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2. ADMINISTRATOR RESPONSES

- Site administrator assures notification to:
 - Area Director/Health Service Administrator
 - Chief of Staff /Residential Medical Director
 - Communications
 - Administrator on call after normal business hours

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Each individual named above is responsible for ensuring appropriate escalation up to and including their Vice President. The Vice President for the area involved in the event is responsible for escalating to the CEO.

- Confirm appropriate degree of harm in the PSLs system, consult QRA staff as needed

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- Appoint person to assist the MRP regarding initial disclosure with Patient/ family and to coordinate ongoing communication with family. Document this discussion in the health record. Refer to Policy [AH0400 Disclosure of Adverse Events](#).
- Ensure appropriate Critical Incident Stress de-briefing of Interior Health staff as necessary see 3.2 a)iii
- Connect with the applicable Human Resource Business Partner to discuss potential performance related processes to be followed as appropriate
- Notify Director Risk Management.

0 – 24 hrs

3. DIRECTOR RISK MANAGEMENT notifies:

- Vice President Medicine & Quality
- Corporate Director Quality Risk & Accreditation
- Network Director as appropriate
- Ministry of Health Executive Director Performance and Issues Management
- Health Care Protection Program and remains contact
- Patient Care Quality Office to identify Patient liaison where appropriate
- As per Appendix E the Director of Risk Management (or delegate) with the appropriate individuals (Decision Review Team) will:**
 - Determine the type of Critical Incident review necessary and applicable protection of review
 - The composition of a Critical Incident Review Team
 - Appoint a person as the **Investigation Coordinator - Lead (Patient Safety Investigator)** Coordinates the ongoing investigation and ensures appropriate communication to individuals who need to know.

4. VICE PRESIDENT COMMUNICATIONS AND PUBLIC AFFAIRS notifies:

- Government Communications and Public Engagement as applicable

Events occurring at a Contracted Partner site:

Contracted Licensed Sites

5. MANAGER OF LICENSING (or delegate) on becoming aware of an event resulting in severe harm or death at a Licensed Contracted Partner site will notify:

- The Chief Medical Health Officer
- The Area Administrator for the site*
- The Director of Risk Management
- Communications
- Director of Community Care Facility Licensing, Ministry of Health

*Contracted Licensed Site is still responsible to notify the Interior Health Area Administrator

Contracted Non-Licensed Sites

6. CLINICAL LEAD who holds the contract (or delegate) on becoming aware of an event resulting in severe harm or death at a contracted non-licensed site will notify:

- The Area Administrator for the site
- The Director of Risk Management
- Communications

0 – 24 hrs

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7. The Area Administrator will proceed as per bullet 2 above "Administrator Responses". Likewise the Director of Risk Management will proceed as per bullet 3 above and the VP Communications and Public Affairs will proceed as per bullet 4 above.

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APPENDIX D

NEVER EVENTS

Never events are patient safety incidents 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, 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.

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

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APPENDIX E

CRITICAL INCIDENT REVIEW PROCESS: TEAMS, ROLES, AND RESPONSIBILITIES

A critical incident Decision Review Team (DRT) must be constituted to review all incidents that are:

1. Determined after review by the *Director of Risk Management or delegate* to be a severity Level 4 or Level 5 (Death) and excluding expected death as reported in the Patient Safety Learning System.
2. Reported to Licensing/or Clinical Leads by our Contracted Partners that meet the criteria for Level 4 or 5. This event will be reported by the Manager of Licensing/Clinical Leads to those indicated in Appendix C Bullet 5 and 6 and are subject to the same Critical Incident Review Process as events occurring in IH owned and operated facilities.
3. Others as requested by the Senior Executive Team.

A critical incident Decision Review Team meeting will be organized within 72 hours and take place within 5 business days following the reporting of an incident in PSLs. The meeting will be convened by the Director Risk Management or delegate and may take place sooner if deemed necessary.

The DRT will include the following individuals (or a delegate):

- Director of Risk Management
- Manager Patient Care Quality Office/Patient Safety Investigations
- Executive Medical Director Quality & Patient Safety
- Executive or Corporate Director for the area/site involved
- Executive Medical Director for the area/site involved
- Administrative Director for the area/site/program/network involved
- CoS (or equivalent medical leadership position) for the area/site
- Network/Program Leads and Medical Director
- Patient Safety Investigator (and/or individual) presenting case summary
- Manager of Licensing where a licensed facility both Contracted Partners and IH owned and operated is involved
- Director of Contracted Services for Contracted Partners
- Others may be invited at the discretion of the Director of Risk Management and on request.

The group shall determine:

1. If a critical incident review is necessary based on whether or not harm has occurred, and if so, was there a contribution to the harm from healthcare delivery;
2. The type of review: i) a critical incident review (in most instances), ii) an accountability review (in very few cases);
3. If a critical incident review will it be: i) comprehensive, ii) concise, or iii) aggregate;
4. If protection from section 51 of the Evidence Act is appropriate;
5. The responsibility for leading the review: i) PSI led, ii) site/program/network led;
6. The composition of the Critical Incident Review Team (CIRT) may include:
 - PSI
 - CoS for the site/area
 - HSA, or site Administrator for the site/area
 - Department Head
 - Director Health Services and/or managers of the Service/Unit
 - Clinical expert reviewers - physician, other clinician, Professional Practice Office as required (may be internal or external to site or IH).

Criteria for a comprehensive review:

- has systems implications
- has learning potential that crosses many jurisdictions
- has complexity
- has broader IH wide application
- is amenable to recommendations
- a similar review has not been done recently
- capacity exists

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7. If there are concerns about possible criminal activity, a Decision Review Team Lead or a Critical Incident Review Team Lead may make recommendation to the appropriate senior leader for follow up.

Consideration should be given to excluding certain individuals as members of Critical Incident Review Team (CIRT), specifically anyone who:

1. was or is directly involved in providing care to the Patient;
2. has a potential future role in disciplinary matters or other conflict of interest which may arise from the incident; e.g. Manager/Area Director, Chief of Staff, Medical Director;
3. is the ongoing Patient/family support person.

The investigative lead will:

1. Reconstruct the sequence of events and as appropriate:
 - a. Debrief (hear the story of) involved staff and physicians;
 - b. Debrief (hear the story of) involved Patient and family (where possible and/or required and/or appropriate);
 - c. Review Health Records;
 - d. Consult with and review findings of clinical experts and other relevant parties;
 - e. Become handler of the event in PSLS.
2. Review applicable policies, procedures, guidelines, protocols and standards.
3. Prepare the initial reports for the Critical Incident Review Team and final reports following deliberation of the Critical Incident Review Team (CIRT) and Decision Review Team (DRT).
4. Ensure Section 51 protection is applied as appropriate.
5. Ensure all Critical Incident Review Team members understand the applicable protection and their roles as Critical Incident Review Team members.
6. Delegate any of the above responsibilities to members of the Critical Incident Review Team as appropriate.
7. Sends the final Patient Safety Learning Summary to the Local Quality Committee and the Quality Improvement Summary to the appropriate leadership teams and Medical Advisory Committee as determined
8. Forwards the Quality Improvement Summary with Health Authority-wide applicability to the Senior Executive Team, Health Authority Medical Advisory Committee, and the Board Quality Committee through the Director Risk Manager/ Executive Medical Director, Quality & Patient Safety.
9. Ensures sites and individuals are assigned responsibilities with support of local quality manager.

- Critical incident review team final reports:
- full report (for CIRTs)
 - PSLS Summary (for local quality committees)
 - Quality Improvement Summary (for MACs, leadership teams)
 - PSLS alerts (if applicable)
 - Recommendation Tracking Sheet/Action Plan (for sites)

The Critical Incident Review Team members will:

1. Perform assigned responsibilities as per bullet 6 above.
2. Ensure they are adequately prepared at Critical Incident Review Team meetings by:
 - a. Reviewing all materials prepared and presented by the investigative lead prior to the meeting day and time;
 - b. Ensure they understand the necessary protection as described by the investigative lead.
3. Determine both locally actionable recommendations and recommendations which may have impact across the Health Authority or provincially and clearly identify the level for implementation of recommendations.
4. Review and approve the final report of the investigative lead.

Special situations of a Critical Incident Review Team:

1. If during the course of the review, serious concerns about the competence or performance of a provider are identified, a Critical Incident Review Team should contact the appropriate senior leader (administrative or medical);

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2. If a Critical Incident Review Team member has a mandatory reporting duty under the Health Professions Act or other legislation, the Critical Incident Review Team should make the disclosure through the appropriate senior leader (administrative or medical);
3. If there are concerns about possible criminal activity, a Decision Review Team Lead or a Critical Incident Review Team Lead may make recommendation to the appropriate senior leader for follow up.

The existence of a Critical Incident Review Team does not preclude the possibility of a parallel investigation by other departments or external bodies, for example:

1. Patient Care Quality Office
2. Risk Management
3. Departmental M&M or quality review
4. Network or program quality review
5. External legal counsel
6. Office of the Coroner
7. Licensing

Where a parallel investigation has occurred the findings and recommendations should be shared with the Critical Incident Review Team to inform the final report (where appropriate).

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