AK0400 – Recognizing and Responding to Hazards, Near Misses and Adverse Events

1.0 PURPOSE

To provide Interior Health (IH) employees and medical staff with a standard approach to managing patient safety hazards, near misses and adverse events.

To ensure that IH employees and medical staff support and treat patients and their families with dignity, respect, compassion and empathy when responding to harm.

To minimize the impact of second harm on IH providers and others affected.

2.0 DEFINITIONS

Accountable leader	The individual who has ultimate accountability to ensure the consideration and completion of the listed steps in the IH Ongoing Management of Adverse Events guideline. 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 who 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

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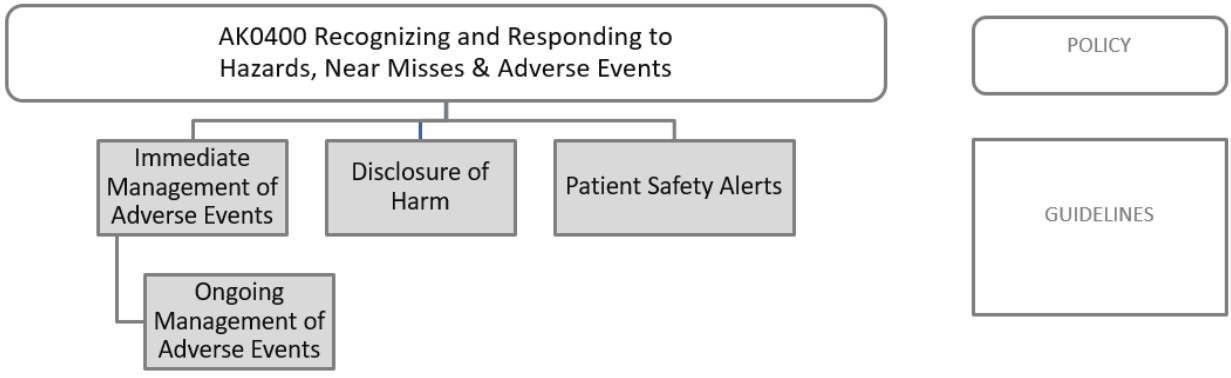
	3 – Moderate harm 4 – Severe harm 5 – Death
Hazard	A circumstance, agent or action with the potential to cause harm.
Most Responsible Practitioner (MRP)	The Most Responsible Practitioner is the Physician, Nurse Practitioner, Oral Surgeon or Midwife whose name appears in the patient's chart designated 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.[9]
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.[7]
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.[11]

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



3.0 POLICY

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3.1 IH leaders become aware of patient safety hazards, near misses and adverse events (AEs) through a number of different ways, including:

- Verbal or email notification from employees or medical staff;
- A report through the Patient Safety Learning System; or
- A report from a patient, resident, family member, volunteer or visitor at the point of care or through other pathways such as IH Communications, a member of the Senior Executive Team, MLA, or the Patient Care Quality Office.

3.2 Immediate Management of AEs

3.2.1 Immediate management of AEs will be coordinated by a single clinical leader who will ensure a fair and consistent response in accordance with the AK0400 Guideline 1.1 Immediate Management of Adverse Events.

3.2.2 Immediate management of an AE shall be started as soon as they are identified and concluded as soon as feasible, ideally within 24 to 48 hours after becoming aware of the event, as per the AK0400 Guideline 1.1 Immediate Management of Adverse Events. Complex events (eg. involving more than one department, area of care, facility, multiple providers involved) may take longer to complete.

3.2.3 During immediate management, the clinical leader must consider the following elements:

- physical and psychological support for patients and/or family;
- physical and psychological support for employees and medical staff;
- environmental safety for patient and/or family, visitors, volunteers, employees, and medical staff;
- disclosure;
- documentation; and
- notification to the employees or medical staff involved (if not already aware), the MRP and the supervisor/manager of the area (and others within the circle of care) as applicable.

3.2.4 Management of an AE can be concluded after the immediate management stage if the AE meets ALL of the following criteria:

- the outcome of the AE on the patient and providers did not cause serious physical/psychological harm or death; and
- the AE does not meet the definition of a Never Event; and
- the clinical leader determines there is no need for further investigation.

3.2.5 If the criteria outlined in section 3.2.4 are not met, the clinical leader will hand over the management of the AE to an accountable leader as per the AK0400 Guideline 1.2 Ongoing Management of Adverse Events.

3.3 Ongoing Management of AEs

3.3.1 Ongoing management of AEs will occur for any of the following criteria:

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- for all critical incidents where the outcome of the AE on the patient or provider is serious (i.e., severe physical/psychological harm or death);
- for all Never Events;
- where the clinical leader determines there is a need for further investigation to fully understand what has happened;
- at the discretion of the accountable leader for extenuating circumstances.

Unresolved concerns from patients and/or family members may also require ongoing management (eg. additional disclosure conversations; complaints escalation process).

3.3.2 A fair and consistent process shall be utilized by the accountable leader in accordance with the AK0400 Guideline 1.2 Ongoing Management of Adverse Events.

The accountable leader may be a department leader, clinical operations director, program director, network director, or other administrative leader as determined by the circumstances.

In deciding who the accountable leader shall be, consider an individual who:
- has accountability for the operational area that the AE occurred;
- has the authority to make decisions and take actions as outlined in the AK0400 Guideline 1.2 Ongoing Management of Adverse Events, and
- with consideration for patient preference if applicable and possible.

In complex AEs that affect multiple areas, the accountable leader will be determined collaboratively (can be facilitated by IH Patient Safety) by the leadership teams of the affected areas or one can be appointed by the executive director of the clinical operations area.

3.3.3 Clinical leaders and accountable leaders may consult with IH Patient Safety for assistance.

3.3.4 Ongoing management of an AE starts when the clinical leader completes handover to the accountable leader, ideally within 24 to 48 hours of identifying the AE. Although ongoing management of an AE may take weeks or months to conclude depending on complexity, it will be prioritized to minimize any delays.

3.3.5 Ongoing management follows the immediate management process and the accountable leader has additional responsibilities related to the following elements:
- receiving handover from the clinical leader;
- clinical and psychological support for patients;
- clinical and psychological support for employees & medical staff;
- environmental safety for patients, visitors, volunteers, employees and medical staff;
- disclosure;
- documentation;
- notification internally and externally as required; this includes determining whether the event requires timely notification of the appropriate Vice President and/or Executive Medical Director either directly or through the *Urgent Notification to SET On Call of an Emerging Issue or Event* process. For select events with an outcome of serious harm or death and/or Never Events, IH Patient

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Safety may directly notify the Vice President Medicine & Quality and the President & Chief Executive Officer;
- initial review of the AE;
- follow up after the AE review.

3.3.6 With support from IH Patient Safety as needed, the accountable leader shall take steps to share what was learned from the review of an AE with relevant patients and families as well as other stakeholders, and ensure that effective actions are taken to improve quality and safety.

3.4 Disclosure of Harm

3.4.1 Patients are entitled to receive the facts about their care and treatment.[3] Health-care providers have an ethical, legal and professional obligation to disclose harm.[4,5,6,7] In accordance with the AK0400 Guideline 1.3 Disclosure of Harm, IH expects disclosure conversations to be conducted with patients if:
- The patient has suffered any degree of harm,
- there is any risk of potential future harm, or
- if there is any change in care or monitoring in order to reduce the impact of future harm.

Effective and timely communication with a harmed patient and/or family can restore trust and improve patient outcomes. The disclosure process is a critical part of re-establishing the provider-patient relationship and restoring confidence after harm has occurred. Additional support for disclosure coaching and training is available within IH.

3.4.2 As part of the disclosure, patients and/or family should receive:
- An acknowledgement that something has gone wrong and an apology;
- The most accurate factual understanding about what happened, without speculation;
- An understanding of the recommended next steps in clinical care or how their care plan may be effected;
- A genuine expression of concern and regret;
- An understanding of how Interior Health will respond to the event and what next steps will look like; and
- Lessons learned from the event and any actions arising from discussions to improve quality of care.

3.4.3 The MRP should lead the disclosure conversation, but other considerations for selection of the lead may include knowledge of the event, strength of existing relationships with the patient and/or family, status of disclosure training, and their understanding of the effect on the patient's medical condition and care plan.

3.4.4 A complete, accurate and factual account of all disclosure discussions must be recorded in the patient's health record including:
- Time and place of disclosure meetings, copies of any disclosure letters provided to the patient and/or family, and details of phone conversations or other methods of communication,
- Identity of all attendees,

- Consents obtained,
- The facts of the event that are known at the time of the disclosure and who presented them,
- Offers of assistance to the patient and response to the offers of assistance,
- Care and treatment plans discussed and provided,
- Requests and actions to review the patient's health record,
- Questions raised and answers given,
- List of any unanswered questions from the patient and/or family, and
- Plans for follow-up, including key contact information from the appointed contact person.

3.5 Patient Safety Alerts

3.5.1 When patient safety alerts (notifications from internal or external sources) are received, a patient safety alert is disseminated through appropriate channels as per the AK0400 Guideline 1.4 Patient Safety Alerts.

3.5.2 IH Patient Safety, in conjunction with the clinical networks as appropriate, can support the distribution of timely, targeted and user-friendly information, including known facts and risk mitigation strategies, to internal and external stakeholders/partners in order to support patient safety and promote a Just Culture.

4.0 PROCEDURES

Please see the following four (4) guidelines describing procedures associated with policy AK0400 Recognizing and Responding to Hazards, Near Misses and Adverse Events:

a. AK0400 Guideline 1.1 Immediate Management of Adverse Events.
b. AK0400 Guideline 1.2 Ongoing Management of Adverse Events.
c. AK0400 Guideline 1.3 Disclosure of Harm.
d. AK0400 Guideline 1.4 Patient Safety Alerts.

5.0 REFERENCES

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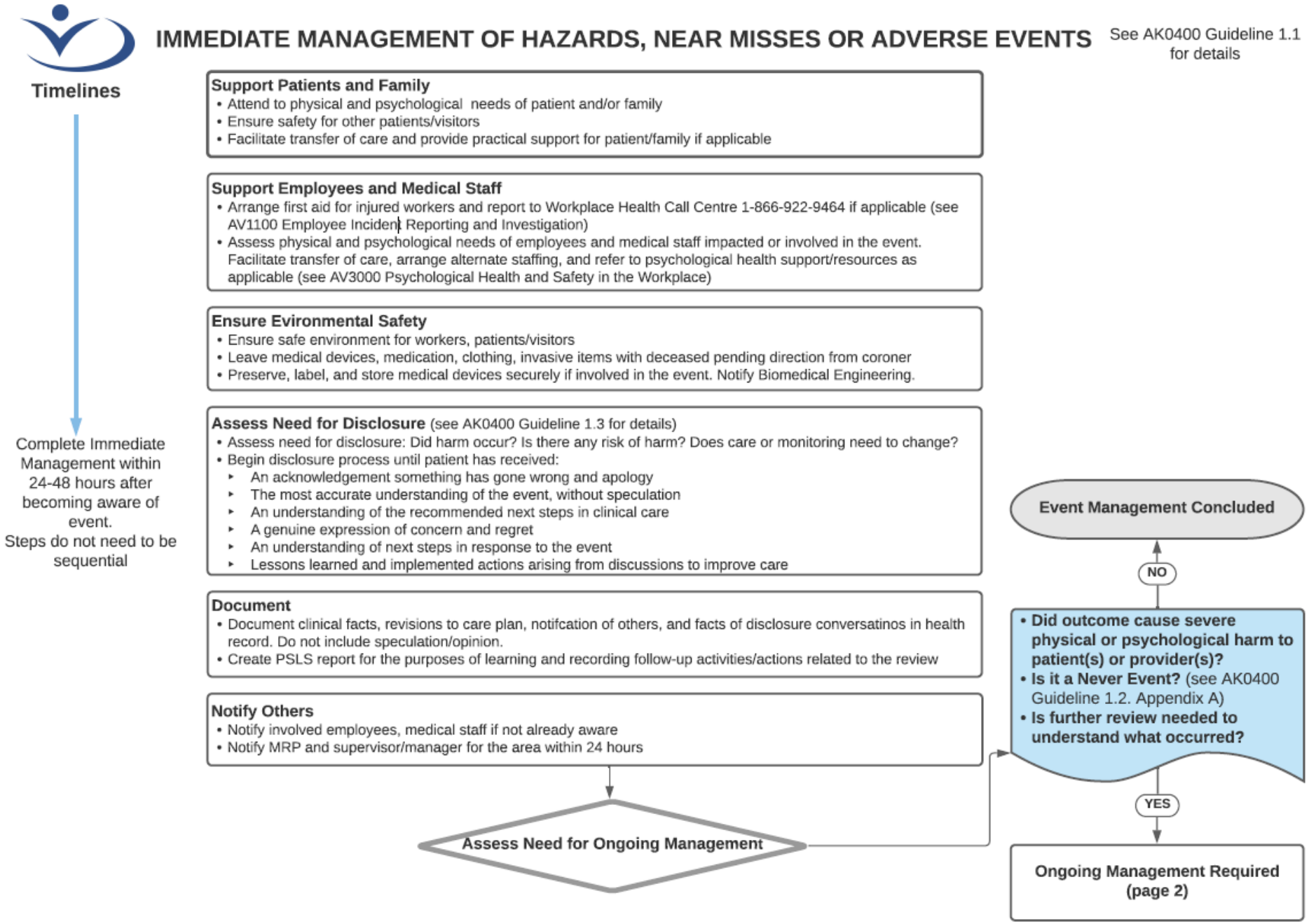
Appendix A Algorithm for Immediate and Ongoing Management of Hazards, Near Misses or Adverse Events



ONGOING MANAGEMENT OF HAZARDS, NEAR MISSES OR ADVERSE EVENTS

See AK0400 Guideline 1.2 for details

Timelines

Complete Ongoing Management within 30-60 days of becoming aware of the event. Timelines are dependent on complexity of event and capacity of reviewers and interviewees

- Establish point of contact for patients/family members for support and communication
- Reassess patient/family need for practical supports (parking, food, transportation, accommodation, access to health records, quiet space)
- Reassess needs for psychological support for affected employees, students, volunteers, medical staff, and refer if necessary
- Consider who else needs to be notified:
  - Chief of Staff
  - Medical Staff Department Head
  - Executive Medical Director
  - Clinical Network Director
  - Clinical Operations Leaders
  - Relevant VPs
  - IH Patient Safety
  - IH Risk Management
  - IH Communications
- Consider need for reporting to external agencies
- Initiate a review of the event (with support from IH Patient Safety) to determine facts. May include development of a clinical timeline, review of health record, discussions with patient/family or providers.

Assess Need for Further Review

- **Have the facts of the event been determined?**
- **Have we learned enough to inform the disclosure process?**
- **If systems issues were identified, are they already known and being addressed?**

NO

Convene Decision Review Team meeting (with support from IH Patient Safety)

Decision Review Team Assesses Need for and Type of Further Review

- Critical Incident Review
- Quality Review
- Accountability Review

YES

Follow up with Patients/Family and Employees/Medical Staff

- Ensure they have received the most accurate understanding of what occurred
- Share implemented actions taken

Share learning from the review with appropriate stakeholders (with support from IH Patient Safety)

Event Management Concluded