# Addressing Patient Safety Events

## For Northern Health Co-Leaders

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# What is a patient safety event?

A patient safety event is an unexpected, undesired event directly associated with care or services provided by the hospital. It results in harm, or potential for harm, to the patient.

# What are the different categories of patient safety events?

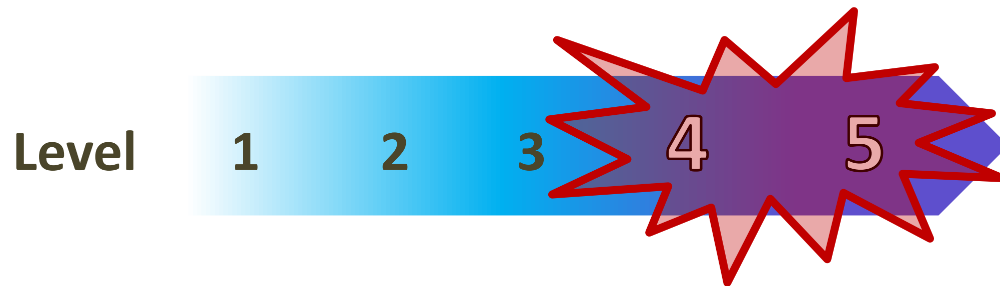
| | |
|---|---|
| Level 1 | • ? |
| Level 2 | • ? |
| Level 3 | • ? |
| Level 4 | • ? |
| Level 5 | • ? |

# What are the different categories of patient safety events?

| Level | Description |
| --- | --- |
| Level 1 | • No harm to patient |
| Level 2 | • Minor harm to patient |
| Level 3 | • Moderate harm to patient |
| Level 4 | • Severe harm to patient |
| Level 5 | • Death |

# Critical Events

- Level 4 and 5 events are considered "critical events."
- In addition to reporting them on the PSLS, staff must follow the critical events checklist.



# Why do I need to know this?

By reporting and reviewing patient safety events, we can make improvements to our processes and practices, and ensure we provide the highest standard of care possible.

Medical and Administrative Leaders have a shared responsibility to: identify and monitor metrics assessing the quality and safety of care provided within the HSDA; collaborate on risk management and quality improvement; respond to complaints about the quality of patient care and access.

# Managing Risk: Reporting “no-harm” events

“No-harm” events sometimes result from a good catch! We can learn from these events. In this case, the question we ask is, “What went right?”

Other times, we’ve just been lucky. We want to capture the no harm events for the same reason we want to capture the other events - to continuously improve our systems and processes.

# What is Section 51?

It is a section in the BC Evidence Act that allows you the freedom to discuss or critique a case or event, without having your thoughts or opinions entered into evidence in any possible legal proceedings. It is meant to ensure that hospitals and health care professionals can constantly review and improve services and procedures, without fear of reprisals.

But, there is a catch!

# What’s the catch?

1. Not all communications are protected.
2. You still have an obligation to disclose adverse events to patients.

To be protected under Section 51, you must follow a set process. Your discussions must take place in a Quality Assurance process, within a “properly constituted Quality Assurance committee.”

Don’t wait to invoke Section 51. Ensure that your communications are protected right from the start.

# Your Quality Assurance Committee

- Who is on the Committee?
- How do you convene them?
- What is your communication process?

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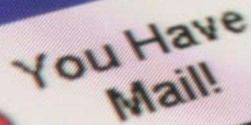
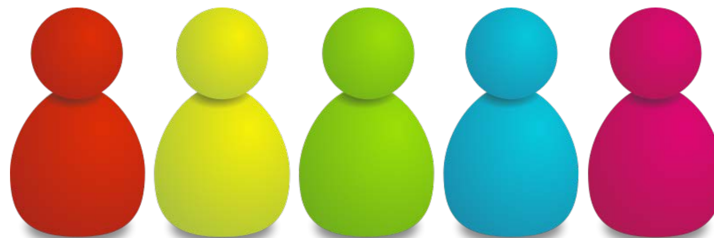
# Who else is notified?




- The Chief of Staff and the NH Risk Management Office automatically receive a notice from the PSLS system when a level 4 or 5 critical event (severe harm or death) occurs in their facility.

- It is the Handler's responsibility to follow up on the report.

Who do you work with when conducting a Review?



# Who will I need to work with?

In addition to the individuals involved in a specific event, you will need to liaise and coordinate your activities with other individuals in your organization.

1. The PSLS Coordinator and/or Quality Leads will generate, monitor and review PSLS reports for quality improvement processes and staff education.
2. Hospital Administration and NH Risk Management should be included on your Adverse Event Review Team.
3. Share your findings with hospital administration and seek their cooperation with implementing changes.

Next

# What are the 3 types of reviews?

1. Administrative Review
2. Accountability Review
3. Quality Assurance Review

For the most part, you will be conducting Accountability Reviews and Quality Assurance Reviews.

# Administrative Reviews

These will normally be conducted by hospital administration, and concern non-medical services or practices.

For example, an audit of hours kept doing house-keeping.

# Accountability Reviews

These are typically human resources (HR) reviews, and focus on the conduct or performance of an individual health care provider.

# Choosing the right review type

1. Is it alleged there is a deliberate violation of sound policy by an individual provider?

2. Is there a concern about the health of the provider?

3. Is the dominant concern in this case about the clear lack of knowledge or skills, or significant unprofessional conduct by an individual provider?

NO to all questions

YES to any questions

Quality Assurance Review

Accountability Review

# Who secures the documents & equipment related to the adverse event?

1. Someone must secure the scene of the event
2. Items relevant to the event must be secured and saved
3. Documentation relevant to the event should be gathered, secured and saved.
4. Depending on the timing and severity of an event, a patient's health records/chart, or a certified copy, should be secured.

Who will do this - Administration, the Handler, or the Medical Leader?

# Scenario- adverse events

Jiang was hooked up to oxygen. When the nurse checked on Jiang half an hour later, she was blue. The nurse realizes that the oxygen is not flowing. Jiang suffers permanent brain damage.

Dr. Cross is the designated handler. Who does she need to contact? What steps must she take?

# Scenario- adverse events

In addition to securing a certified copy of Jiang's chart, Dr. Cross also works with Hospital Administration to ensure that the equipment is secured, photos of the scene have been taken, and checks with security to see if there is video footage that could help determine what happened.

# Related Legislation, Policies & Guidelines

Health Care Protection Program. (December 2013). *Section 51 of the Evidence Act: Toolkit for Health Care Agencies.*

# Where Can I Find PSLS Training?

If you are looking for PSLS specific training, online training is available through the BC Patient Safety and Learning System: http://bcpslscentral.ca/elearning-modules/

You can also contact the Northern Health PSLS Coordinator at: PSLS.Information@northernhealth.ca

Find more information through Northern Health at: https://ournh.northernhealth.ca/QualPatientSafety/PSLS/Pages/PSLS.aspx

# Related Legislation, Policies & Guidelines

- BC Patient Safety Learning System (PSLS). (accessed January 2021). Website. http://bcpslscentral.ca/
- Northern Health Medical Affairs & Risk Management. (revised December 2020). Addressing Patient Safety Events: Summary for Northern Health Co-Leaders. https://physicians.northernhealth.ca/physician-resources/orientation-education#education-for-medical-staff-leaders
- Canadian Patient Safety Institute. (2011). *Canadian Disclosure Guidelines: Being Open with Patients and Families.* https://www.patientsafetyinstitute.ca/en/toolsResources/disclosure/Pages/default.aspx
- Northern Health. (Sept 2018 ). *Disclosure of Adverse Events* https://ournh.northernhealth.ca/PoliciesProcedures/DST%20Published%20Policies/4-2-3-030.pdf
- Province of BC. (Dec 2020). *BC Evidence Act*, Section 51. https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96124_01

# For more information

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