

**NOVA SCOTIA DEPARTMENT OF HEALTH
CONTINUING CARE BRANCH**

Subject: Critical Incident Reporting Policy

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Approved by:



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1.0 INTRODUCTION

1.1 The Nova Scotia health system continuously strives to maintain and improve on the safety of healthcare practices and the environment in which health care and services are provided. This can, in part, be achieved through the review and analysis of actual or potential incidents which pose risks to an organization, its personnel and suppliers, and the people receiving its services. When shared across the health system, lessons learned from such reviews can facilitate process improvement and hazard prevention. The Nova Scotia Department of Health plays a coordinating role in ensuring that relevant safety information is collected and disseminated across the health system in a systematic fashion.

In maintaining and improving the quality of the health care system, Continuing Care service providers and the Department of Health have individual responsibilities:

Continuing Care service providers have a responsibility to:

- I. investigate and take action on critical incidents;
- II. report critical incidents to the Department of Health; and
- III. work with the Department of Health and other agencies in delivering public communication about incidents or events when confidence in the healthcare system is at issue.

The Department of Health has a responsibility to:

- assess critical incidents for broad system practice and policy implications;
- issue associated system alerts;
- address policy changes;

work with Continuing Care service providers in delivering public communication about incidents or events when confidence in the healthcare system is at issue.

2.0 POLICY STATEMENT

- 2.1 Continuing Care service providers are required to report critical incidents to the Nova Scotia Department of Health. Service Providers are defined in section 4.0 - 6 of this policy.

3.0 POLICY OBJECTIVES

The objectives of this policy are to:

- 3.1 provide a consistent process for Continuing Care service providers to notify the Department of Health of critical incidents; and
- 3.2 provide timely information that will facilitate policy and process improvement across the health system

4.0 DEFINITIONS

- 1 **Adverse Event:** An unexpected and undesired incident directly associated with the care or services provided to the client or the environment in which the care is provided, resulting in harm and/or death.
- 2 **Authorized decision maker:** Anyone who has legal authority to make decisions on behalf of an individual. This is often referred to as legal representative or substitute decision-maker and includes, but is not limited to, persons who have authority under the Hospital Act, Medical Consent Act, the Power of Attorney Act, under a guardianship order, other relevant legislation or applicable health care agency policy (such as consent policy).
- 3 **Client:** An individual who receives care or service from service providers referred to in this policy; this includes those referred to as patients or residents and their families, where appropriate, and authorized decision-makers for the client.

- 4 **Critical Incident:** A critical incident is a serious event, effecting either the client, staff of service providers or the public including, but not limited to:
 - a. the actual or potential loss of life, limb or function related to a health service provided by, or a program operated by, a service provider
 - b. an event that has or may have a negative impact on service operations
 - c. an event that poses a threat to public health or;
 - d. an event that may have a negative impact on the public trust in the health care system.

- 5 **Disclosure:** The imparting, by health care-workers to clients of information pertaining to any adverse event affecting (or liable to affect) the client's interests.

- 6 **Harm:** An outcome that negatively affects the client's health and/or quality of life

- 7 **Continuing Care Service Providers:** The Nursing Homes and Homes for the Aged, Residential Care Facilities (RCF), Community Based Options (CBO) and Home Care Agencies which are funded, licensed or approved by Department of Health, Continuing Care Branch.

- 8 **Incidents:** Events, processes, practices, or outcomes that are noteworthy by virtue of the hazards they create, or the harms they cause. {Adapted from CCHSA}.

- 9 **Near Miss:** A near miss is an event or circumstance which "almost happened" but may not have reached the client due to chance, corrective action, and/or timely intervention.

- 10 **Sentinel Event:** A sentinel event is an adverse event which leads to death or major and enduring loss of function for a recipient of healthcare services. Major and enduring loss of function refers to sensory, motor, physiological or psychological impairment not present at the time services were sought or began. The impairment lasts for a minimum period of two weeks and is not related to an underlying condition. {Adapted from CCHSA}.

5.0 POLICY APPLICATION

- 5.1 This policy applies to all Continuing Care service providers, receiving public funds to deliver health care service.

6.0 POLICY DIRECTIVES

- 6.1 Continuing Care service providers manage critical incidents according to their own administrative and quality management policies.
- 6.2 **Continuing Care service providers shall notify the Department of Health about critical incidents which may include, but are not limited to:**
- 6.2.1 preventable death or serious health impairment to a client, visitor or health care personnel directly associated with care and services provided by a health care agency;
- unanticipated disruption to healthcare services greater than twenty-four hours duration;
 - privacy breach;
 - events which involve multiple clients and/or require retroactive notification of groups of clients about an event or exposure risk;
 - criminal activity (such as abduction, sexual assault, major theft or embezzlement);
 - conditions perceived as public health hazards or disaster management events;
 - events which have the potential to undermine public confidence in the health care system; and,
 - if none of the above applies, Continuing Care service providers should use their judgment in reporting actual or potential critical incidents that may represent hazards across the health system.
- 6.3 The Department of Health and Continuing Care service providers shall participate in collaborative communication planning when informing the public about major critical incidents.
- 6.4 Continuing Care service providers shall participate in inter-organization action and/or provincial review of practices or policies when appropriate.

7.0 PROCEDURES

- 7.1 Continuing Care Service Providers should report critical incidents to the Department by the end of the next Business Day.
- 7.1.1 A senior administrator, designated by the Continuing Care service provider, shall contact the Department of Health staff by fax.
- 7.1.2 During regular working hours Continuing Care service providers shall call a senior staff member of the program area most relevant to the incident through regular telephone contact mechanisms.

- 7.1.3 In cases of public health hazards, a Continuing Care service providers is required to notify the provincial Medical Officer of Health (MOH) through the established procedures, as set out by MOH
- 7.1.4 Continuing Care service providers should fax the required information to the Service Delivery Consultant, Continuing Care Branch at the fax number noted on the form.
- 7.1.5 Continuing Care service providers shall continue to report disaster management events through the emergency response system.
- 7.2 Continuing Care service providers must communicate factual details of the critical incident and its outcome. To protect confidentiality, the personal information of clients and staff involved in critical incidents are to be de-identified. There shall be no reference to a personal name or other characteristics which in the context of the critical incident would serve to identify an individual.
 - 7.2.1 The following information shall be provided:
 - i. name of agency
 - ii. nature of incident
 - iii. location of incident
 - iv. time and date of occurrence
 - v. brief description of incident
 - vi. impact of incident
 - vii. Service provider contact person and number
- 7.3 At the time of initial contact, or by the next business day, the Department of Health will identify for the Continuing Care service provider the names and contact information of Department of Health staff who are authorized to receive information and status reports about the critical incident on an ongoing basis.
- 7.4 Within thirty working days, the Continuing Care service provider shall submit a written status report on the incident with follow-up action plan to the Department of Health designated staff.
 - 7.4.1 The following information shall be provided, as part of the follow-up action plan:
 - name of the Continuing Care service provider
 - action taken to address immediate safety of clients and staff
 - action taken to prevent reoccurrence
 - target dates for future action, if action not completed

8.0 ACCOUNTABILITY

The Executive Director, Continuing Care Branch is responsible for ensuring compliance with this Policy.

9.0 MONITORING

The implementation, performance, and effectiveness of this Policy will be monitored by the Executive Director, Continuing Care Branch.

10.0 REFERENCES

10.1 This policy is aligned with both the Department of Health and the Continuing Care Branch Disclosure of Adverse Events Policy.

11.0 APPENDICES

11.1 Critical Incident Reporting Form

11.2 Critical Incident Follow Up Form