Patient Safety Incident Management

This is a Required Organizational Practice (ROP) for Accreditation

REPORTING PATIENT SAFETY EVENTS HELPS US LEARN FROM THE EVENT, PREVENT RECURRENCES AND IMPROVES THE CULTURE OF SAFETY.

What is the procedure for reporting a patient safety incident?

- *A Safety Event Report (SER) should be completed whenever a situation presents itself that meets the definition of an Occurrence, Near Miss, Critical Incident or Critical Occurrence.*
- *The procedures for reporting are outlined in the following checklists:*
  ORG.1810.PL.001.SD.02 - Management of a Near Miss and Occurrence Checklist
  ORG.1810.PL.001.SD.03 - Management of a Critical Incident Checklist
  ORG.1810.PL.001.SD.04 - Management of a Critical Occurrence Checklist

What types of incidents should be reported?

- *Whenever an event occurs that falls under the categories:*
  - *Near Miss (NM): An event that happened but did not reach the client or employee.*
  - *Occurrence (O): An event or circumstance where there may be minor or major injury to an individual and/or damage to, or loss of, equipment or property.*
  - *Critical Incident (CI): is an unintended event that occurs when health services are provided to an individual and result in a consequence to him or her that: is serious and undesired such as death, disability, injury or harm, unplanned admission to hospital or unusual extension of a hospital stay; and does not result from the individual's underlying health condition or from a risk inherent in providing the health services.*
  - *Critical Occurrence (CO): An event involving substantial risk or harm to employees, physicians, volunteers, students, visitors and others associated with the organization or to reputation through negative media/social media, security, or property damage of a potential financial loss greater than $25,000.*

Something to Think About/Question a Surveyor Might Ask

What changes have recently been made to improve patient safety within your program/site?

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