nova scotia health | **Policy**

Policy Title:	Patient Safety Incident Management
Applies To:	All Nova Scotia Health Team Members
Related Procedure(s):	Patient Safety Incident Management - Procedure - NSHA AD-QR-015.01

Approved:	**Effective:**	**Next Review:**
July 21, 2022	August 9, 2022	July 21, 2026

Sponsor:	Senior Director, Quality Improvement and Safety
Approval Authority:	VP Medicine Executive Leadership Team

Number:	AD-QR-015	**Manual:**	Administrative

PURPOSE

This policy is part of Nova Scotia Health's system to address Patient Safety Incidents, including Disclosure of Patient Safety Incidents - Policy and Procedure - NSHA AD-QR-010 and Quality Review - Policy and Procedure - NSHA AD-QR-005.

The purpose of this policy and its accompanying procedure is to provide direction for Nova Scotia Health Team Members regarding Patient Safety Incident Management. This policy is intended to promote Patient safety by detailing how Team Members learn from Patient Safety Incidents to make systemic improvements in the provision of health care services.

DEFINITIONS

Contributing Factor	A circumstance, action, or influence which is thought to have played a part in the origin or development of an incident, or to have increased the risk of an incident. Examples of Contributing Factors include Patient characteristics, care team, equipment, task, work environment, organizational, bias-related, and equity.
Disclosure	A formal process involving open discussion between a Patient or where applicable the Patient's Substitute Decision Maker and Nova Scotia Health about a Patient Safety Incident. Refer to NSHA-AD-QR-010 Disclosure of Patient Safety Incidents.
E-Messaging	Messages exchanged between individuals using electronic devices. This includes email, texting/instant messaging, and messages sent

	between individuals through online messaging services/applications, including video conferencing applications.
Health Care Provider	Team Members who are engaged in providing health care and services.
Manager/Director (or Delegate)	Responsible and accountable for standards of care in the clinical unit or service area in which the Patient Safety Incident occurred or potentially occurred.
Patient(s)	All individuals including clients, residents, and members of the public who receive or have requested health care or services from Nova Scotia Health and its Health Care Providers.
Patient Safety Incident	An event or circumstance which could have resulted or did result in unnecessary harm to a Patient (see Appendix A for Severity Levels).
Quality Review	The systematic analysis and evaluation of health service structures, practices, and/or results that focus on the entire continuum of care and services; including, but not limited to, Patient Safety Incidents and individual cases which are reviewed based on predetermined criteria for the purposes of education and/or improvement in and increased safety of health care/service or practice. Review of team/organization/system data and indicators to proactively improve general quality and Patient safety in specific areas of service and the system. Analysis of the Patient and family (as applicable) needs with a view to improve performance, quality, safety, and experience. Refer to NSHA AD-QR-005 Quality Review.
Safety Improvement & Management System (SIMS)	The Nova Scotia Health province-wide reporting and management information system used to enhance the capability of Health Care Providers to improve safety. The electronic Patient Safety Incident reporting system was developed with processes to report, analyze, recommend actions, and monitor improvements.
Team Members	All employees, physicians, learners, volunteers, board members, contractors, contract workers, franchise employees, and those with affiliated appointments and other individuals performing activities within Nova Scotia Health.

PRINCIPLES AND VALUES

1. **Improvement and Learning:** Nova Scotia Health has a responsibility to learn from Patient Safety Incidents and make quality improvements for high quality and safe health services. The primary role of Patient Safety Incident Management is to promote safety by learning from Patient Safety Incidents and to make systemic improvements in the provision of health care and services.

2. **Just Culture**: The importance of fairly balancing an understanding of system failure with professional accountability. A just culture promotes safe care through a consistent, fair culture of accountability, where Patient Safety Incidents and near misses are freely reported, reviewed, and learned from. In a just culture, the reasons for unexpected clinical outcomes and Patient Safety Incidents are not pre-judged and the rights of all individuals, including Patients, are protected. All are aware of Patient Safety Incident reporting expectations, and when analyzing Patient Safety Incident reports, professional accountability of Health Service Providers is determined fairly. Without a just culture, individuals would not feel safe to report Patient Safety Incidents and they would go unreported. This would directly impact the ability to prevent Patient safety issues from recurring in the future.
3. **Confidentiality**: Patient Safety Incident Management is most effectively undertaken in a confidential environment where participants can safely report, participate, and freely discuss the underlying Contributing Factors to the Patient Safety Incident, and thus enhancing the process for learning from Patient Safety Incidents. Quality Improvement information must be kept confidential in compliance with the Quality-improvement Information Protection Act (QIIPA), which prohibits Disclosure and access to Quality-Improvement information except as expressly permitted under QIIPA.
4. **People-Centred Care:** As a foundation of Nova Scotia Health, we are working to place the dignity and respect of Patients, families, and communities at the heart of every decision. Through processes such as Management of Patient Safety Incidents, we seek to build trust-based relationships to achieve more genuine partnerships with those we serve. This policy, in conjunction with others, such as NSHA-AD-QR-020 Family Presence, demonstrate Nova Scotia Health's commitment to people-centred care.

POLICY STATEMENTS

1. This policy applies across all of Nova Scotia Health's services and its direction is required in response to all Patient Safety Incidents.
2. All Team Members are responsible to report Patient Safety Incidents (including Near Misses – See Appendix A: Patient Safety Incident Severity Levels).
3. All Patient Safety Incidents are reported either anonymously or confidentially in the Safety Improvement and Management System (SIMS).
4. All Managers/Directors (or Delegates) are responsible for timely documented follow-up of all reported Patient Safety Incidents. This includes review, appropriate collaboration with others to gather facts, analysis of information, documentation of Disclosure, and participation in identification and implementation of improvement actions and recommendations.
5. All Team Members must follow, as appropriate:
   - 5.1. NSHA-AD-QR-010 Disclosure of Patient Safety Incidents.
   - 5.2. NSHA-AD-QR-005 Quality Review.
6. Nova Scotia Health Manager (or Delegate) is accountable to ensure review, follow-up, and implementation of improvements for all reported Patient Safety Incidents.

7. E-Messaging and voicemail outside the Nova Scotia Health network are not considered secure systems and must not be used to communicate information in relation to specific Patient Safety Incidents and Quality Review proceedings (refer to NSHA AD-AO-045 Electronic Messaging of Personal Health Information).
8. Patient Safety Incident reports (SIMS reports) cannot be released externally from Nova Scotia Health to any person or agency and are deemed protected under the Nova Scotia Quality-improvement Information Protection Act (QIIPA) for the purposes of health care quality improvement (exception: those notifications authorized in SIMS).
   8.1. Patient Safety Incident reports (SIMS reports) must not be:
      - Copied, printed, duplicated, or electronically distributed by any means.
      - Printed or filed to a Patient's health record.
      - Printed or filed to Team Members' employment files.
9. The Quality and System Performance Program, as Nova Scotia Health's data custodian of SIMS, is the official custodian of all Patient Safety Incident reports.
10. All SIMS users must maintain confidentiality of all SIMS information.

REFERENCES

Legislative Acts/References

Province of Nova Scotia. (2014). *Fatality Investigations Act* (Chapter 31 of the Acts of 2001). http://nslegislature.ca/legc/statutes/fatality%20investigations.pdf

Province of Nova Scotia. (2015). *Quality-improvement Information Protection Act* (Chapter 8 of the Acts of 2015). https://nslegislature.ca/sites/default/files/legc/statutes/quality-improvement%20information%20protection.pdf

Province of Nova Scotia. (2014). *Personal Health Information Act*. http://novascotia.ca/dhw/phia/PHIA-legislation.asp

Other

Accreditation Canada. (2020). Required Organizational Practices (ROP's) Handbooks 2020. Accreditation Canada ROP Handbook

Canadian Medical Protective Association (CMPA). (2022) *Good Practices Guide.* https://www.cmpa-acpm.ca/serve/docs/ela/goodpracticesguide/pages/index/index-faculty-e.html

Canadian Medical Protective Association (CMPA). (2009). *Learning from adverse events: Fostering a Just Culture of safety in Canadian hospitals and health care institutions*. https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2009/learning-from-adverse-events-fostering-a-just-culture-of-safety-in-canadian-hospitals-and-health-care-institutions

Canadian Patient Safety Institute, Institute for Safer Medication Practices (ISMP), Saskatchewan Ministry of Health. (2012). *Canadian Incident Analysis Framework.*

https://www.patientsafetyinstitute.ca/en/toolsResources/IncidentAnalysis/Documents/Canadian%20Incident%20Analysis%20Framework.PDF

Healthcare Excellence/ Canadian Patient Safety Institute (2020). *A guide to Patient Safety Improvement. Integrating Knowledge Translation & Quality Improvement Approaches.* https://www.patientsafetyinstitute.ca/en/toolsResources/A-Guide-to-Patient-Safety-Improvement/Pages/default.aspx

Healthcare Excellence/ Canadian Patient Safety Institute (2022). *Disclosure.* *https://www.patientsafetyinstitute.ca/en/toolsResources/PatientSafetyIncidentManagementToolkit/IncidentManagement/pages/disclosure.aspx*

Healthcare Excellence/ Canadian Patient Safety Institute (2019). *Engaging Patients in Patient Safety. https://www.patientsafetyinstitute.ca/en/toolsResources/Patient-Engagement-in-Patient-Safety-Guide/Pages/default.aspx*

Healthcare Excellence/ Canadian Patient Safety Institute. (2022). *Patient Safety Incident Management Toolkit*. http://www.Patientsafetyinstitute.ca/en/toolsResources/PatientSafetyIncidentManagementToolkit/PatientSafetyManagement/pages/Patient-safety-culture.aspx

Healthcare Excellence/ Canadian Patient Safety Institute. (2020). *Safety Competencies Framework. 2nd Ed.* https://www.patientsafetyinstitute.ca/en/toolsResources/safetyCompetencies/Pages/default.aspx

Nova Scotia Department of Health & Wellness. (2021). *Serious Reportable Event Reporting Policy*. https://novascotia.ca/dhw/hsq/documents/Serious-Reportable-Event-Interim-Reporting-Policy.pdf

World Health Organization. (2022). *Patient Safety Action Plan 2021-2030.* file:///C:/Users/blackmoreg/Downloads/9789240032705-eng.pdf

RELATED DOCUMENTS

Policies

NSHA-AD-QR-010 Disclosure of Patient Safety Incidents

NSHA AD-QR-005 Quality Review

Procedures

NSHA AD-QR-015.01 Patient Safety Incident Management

Appendices

Appendix A – Safety Improvement and Management System – Patient Safety Incident Severity Levels

Appendix B – Nova Scotia Health Quality Oversight Structure

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Appendix A: Safety Improvement & Management System - Patient Safety Incident Severity Levels

Severity Level	Definition
Near Miss	An incident that did not reach a person. The incident has potential for harm and is intercepted or corrected prior to reaching a person.
No Harm Incident	An incident that reached a person, but no discernible harm resulted. Outcome is not symptomatic, or no symptoms are detected, and no treatment is required.
Mild Harm Incident	An incident where the outcome is symptomatic, symptoms are mild, loss of function or harm is minimal or intermediate, but short term or minimal intervention is required (for example: extra observation, investigation, review, or minor treatment)
Moderate Harm Incident	An incident where the outcome is symptomatic and requires intervention (for example: additional operative procedure, additional therapeutic treatment) or an increased length of stay; or causing minor permanent, long-term harm or loss of function
Severe Harm Incident	An incident where the outcome is symptomatic, requiring life-saving intervention or major surgical/medical intervention or shortening life expectancy or causing major permanent, long-term harm or loss of function.
Death	Death which may have occurred in association with a Patient safety event or Team Members-related event.

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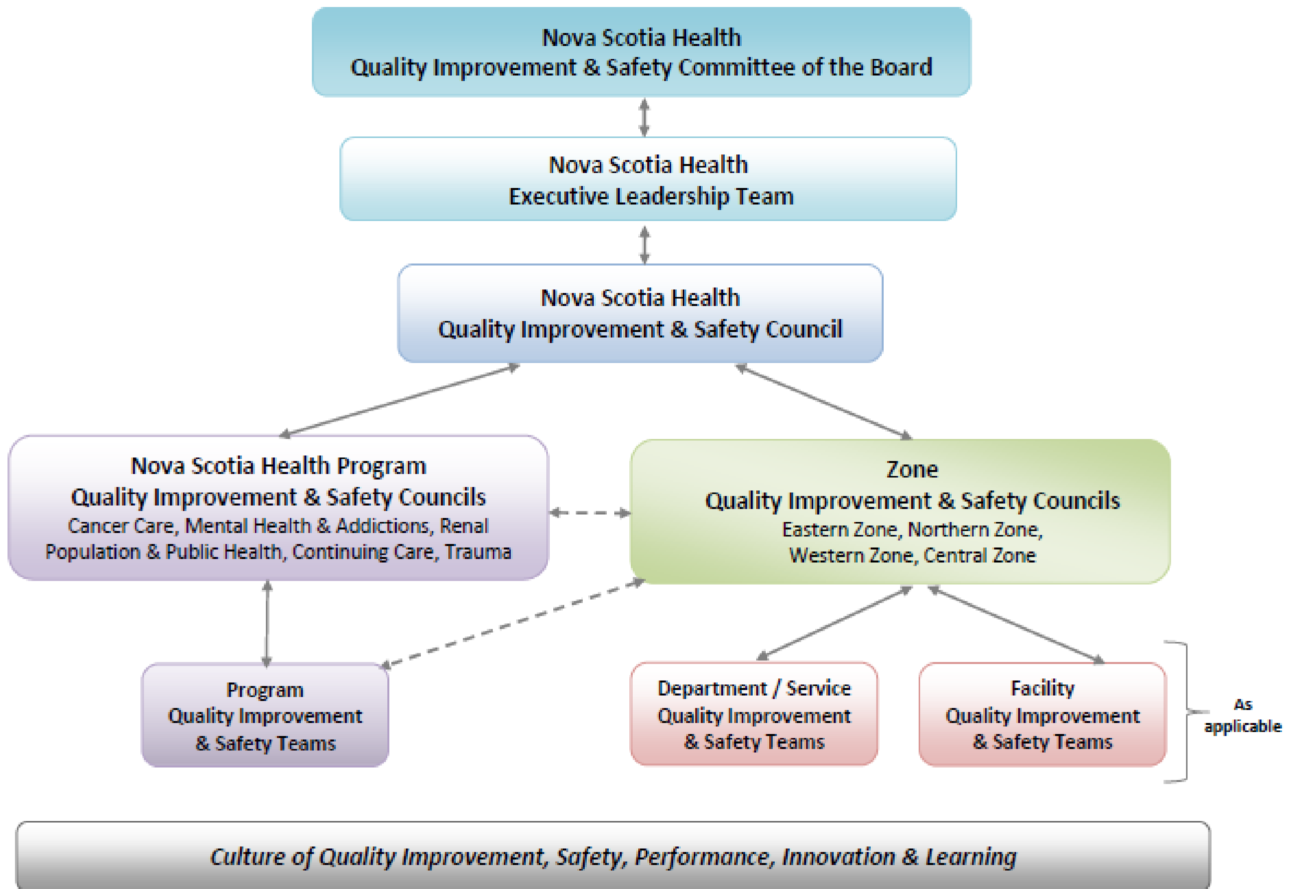
Appendix B: Nova Scotia Health Quality Oversight Structure



VERSION HISTORY

Version:	Effective:	Approved by:	What's changed:
Original	2017-07-17	VP, Quality and System Performance Executive Leadership Team	N/A
Revised	2019-03-25		Changed Link & Updated Style
Revised	2022-08-09	VP Medicine Executive Leadership Team	Regular review and updates