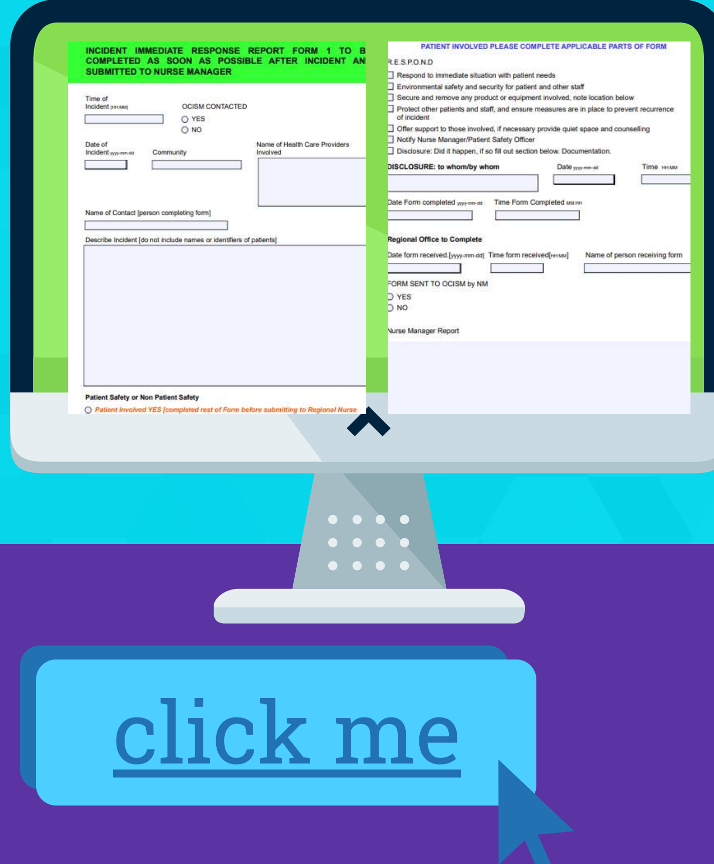
The Incident Report

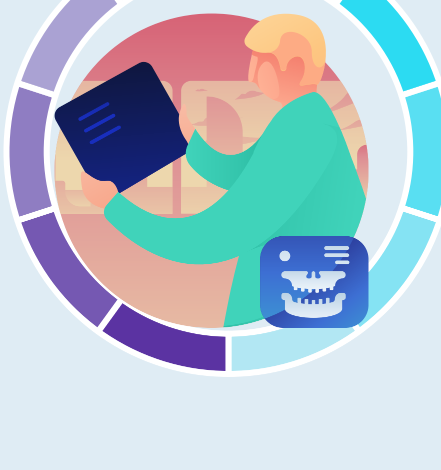
(as it relates to patient safety)



An incident report is intended to enable and support our organizational commitment to work with First Nations, Inuit and Métis to:

- Improve access to high-quality services
- Improve well-being in Indigenous communities across Alberta.

What is it, why it matters and who submits?



It is a place to track near misses, risk situations, adverse events and ; identifies patterns, generates reports, and communicates information for system leaders and staff to take action to reduce harm.

The more reports submitted, the more we as an organization can learn and improve patient safety and the quality of care.

Anyone can submit a patient safety concern.

How do I submit?

1

ONEHEALTH.CA

2

Please Choose Your Region

- BC/Yukon
- Alberta/NWT
- Saskatchewan
- Manitoba
- Ontario
- Quebec
- Atlantic Region

3

Click on:
Patient Incident Form - Green Form

OR

You can also submit by printing off the form and handwriting the incident.

4

Send to your manager **AND** patient safety lead via email or scan.

What to report?

- **Risk situations**- events "***waiting*** to happen" e.g. look alike medication label.
- **Near misses** - events that ***almost*** reached the ***patient*** e.g. urinalysis almost done on the wrong patient.
- **Adverse events** - events that ***reach*** the ***patient*** e.g. patient fall resulting in ***no harm***, medication administration error resulting ***in harm***.

What to include in the submission?

- A brief and objective description of the event.
- If patient safety related, complete the R.E.S.P.O.N.D and disclosure section.

What not to include ?

- Do NOT use identifiers (this includes patients and staff initials and patient identification numbers; use roles (e.g. doctor, nurse, paramedic, patient). With multiple patients and or staff, use Staff 1, 2 Patient 1, 2 etc.
- Performance- related issues (this should be taken to your manager)

Roles

Reporters are responsible for:

- Reporting patient safety risk situation, near misses and adverse events, within 72 hours of the incident. *** sentinel events must be submitted within 24 hours **;
- Notifying the appropriate clinical lead or manager;
- Document adverse event in the health record. Do NOT document in the patient record that an incident report was completed.

Managers are responsible for:

- Responding to reports on a case by case basis;
- Ensuring reports are read, advanced and shared, as appropriate;
- Identifying improvements and analyze trends;
- Provide feedback to staff and medical staff about how reports are contributing to safe quality care.

Patient safety lead is responsible for:

- Tracking all submitted patient safety incidents;
- Preliminary review and classify the incident, select analysis method;
- Analysis process (understand what happened, how and why, develop and manage recommended actions with a team);
- Help with recommendation follow-through; close the loop - share what was learned;
- Develop quarterly reports and analyze trends.

Sentinel event is an incident/error that caused permanent harm or major damage or 3rd party damage; it is an incident that caused unexpected death or damages resulting in long term or permanent closure of the facility

What happens when a report is submitted?

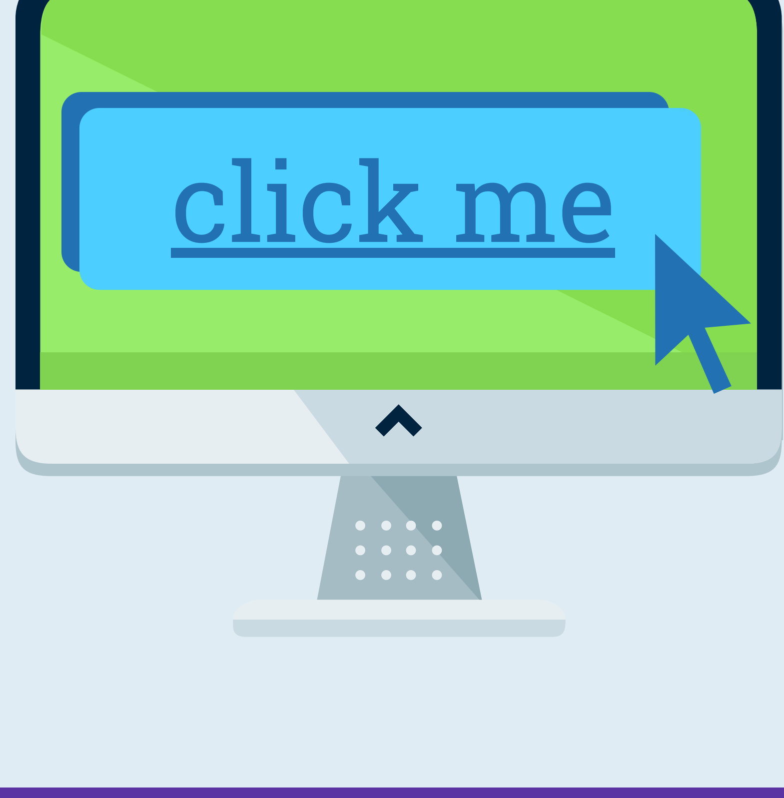
It only takes a few minutes to submit an incident report, but each one is critical to reducing errors and potential hazards. Reports are reviewed by a manager and patient safety lead to determine the cause of the event, and what can be done to prevent it from happening again in the future. Multiple reports about the same event can help by providing different viewpoints and perspectives.

Patient safety lead is here to help! Analysts are available to help reporters submit incident reports.

Just Culture

Indigenous Services Canada emphasizes learning and reporting to enhance safe care for patients and healthy work environments for staff and medical staff. While we will never prevent all mistakes from happening, when hazards and close calls or actual adverse events are identified through the incident report we are able to initiate efforts to support continuous quality and safety improvement.

A Just Culture is an environment where everyone feels safe, encouraged, and enabled to discuss quality and safety concerns.



If you have any question, contact Noelle Hajjar, patient safety lead at 587-385-9597 or noelle.hajjar@sac-isc.gc.ca

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