Non-Hospital Medical and Surgical Facilities Accreditation Program

Bylaw Policy

Patient Safety Incidents Reporting

PURPOSE

In healthcare, patient safety incidents that impact the lives of patients and families, as well as providers and organizations, can and do occur. In recent years, considerable focus on patient safety has been aimed at different levels: the culture of patient safety within health organization; the knowledge associated with patient safety (methods and research); analysis of safety incidents (with resulting learning and improvements); and sharing and communicating this information with others.

The Non-Hospital Medical and Surgical Facilities Accreditation Program (NHMSFAP) Committee recognizes that patient safety incident reviews can provide a positive outcome to assist medical directors and the surgical team in understanding what happened and what improvements can be made to reduce the risk of similar harm to other patients in the future.

POLICY

In accordance with the Bylaws, the medical director must notify the NHMSFAP Committee within 24 hours of becoming aware of the following:

- the patient safety incidents outlined in Appendix A
- any death which has occurred during or within 28 days of a procedure in the facility

All patient safety incidents shall be reviewed by the medical director and reported on a form approved by the committee and must include the details of investigations, outcomes and recommendations. The approved form must be made available to the NHMSFAP committee within fourteen (14) days of notification of the incident.

The medical director must maintain a written log of all patient safety incidents requiring mandatory reporting that includes:

- the name of the patient
- the registrant(s) who performed the procedure
- the date of the incident
- the nature of the incident
- the outcome

DEFINITIONS

patient safety incident (PSI)	An event or circumstance which could have resulted, or did result, in unnecessary harm to a patient.

harmful incident	A patient safety incident that resulted in harm to the patient. (Replaces "adverse event," "sentinel event" and "critical incident.")
no harm incident	A patient safety incident that reached a patient, but with no discernible resulting harm.
near miss	A patient safety incident that did not reach the patient. (Replaces "close call.")

RESPONSIBILITY

Role	Responsibility
Medical director	• Report patient safety incidents and deaths • Submit reports on forms approved by the committee
Senior coordinator, quality improvement and accreditation	• Review forms • Consult with experts as required • Initiate a panel PSI review as required • Summarize reports and recommendations for the NHMSFAP Committee
NHMSFAP Patient Safety Incident Panel	• Make recommendations for the facility based on the PSI review

APPENDIX A: PATIENT SAFETY INCIDENTS REQUIRING MANDATORY REPORTING

The following patient safety incidents must be reported to the NHMSFAP Committee within 24 hours and a written report submitted on a form approved by the committee within 14 days.

1. A change in the type or site of surgery, (including incorrect implant/prostheses implanted)
2. Any wrong side, wrong patient surgery
3. Any unplanned surgery arising as a complication of the planned procedure
4. Any surgical procedure greater than six hours (skin-to-skin time)
5. Any infection requiring:
    a. hospitalization (admission as an in-patient)
    b. a second surgical procedure which occurs as a result of the procedure
    c. ongoing outpatient IV therapy
6. A cluster of infections (more than one occurring on the same day, consecutive surgical cases, consecutive surgical days, same type of surgery)
7. Any occurrence of VTE arising within 28 days of a procedure in a facility
8. Any patient requiring a blood transfusion within 28 days of a procedure in a facility
9. Any unplanned return to the operating room

10. The referral of a patient to a hospital or health-care facility from the non-hospital facility, whether or not the patient is admitted
11. Any unexpected admission to hospital within 28 days after a procedure in the facility
12. Any patient required to stay in a facility for more than 24 hours following a procedure
13. Any death which has occurred during or within 28 days of a procedure in the facility
14. Medication error (including surgical prep solution error)
15. Loss or theft of a controlled drug or substance
16. Medical device reprocessing error (e.g. positive biological indicator, sterilization parameter error, unsterile items used in error)
17. Incorrect count (possible retained surgical item)
18. Near miss (an occurrence that could have resulted in an accident, injury, or illness but did not by chance, skillful management, or timely intervention)

APPENDIX B: REPORTABLE INCIDENT FORM

The Reportable Incident Form is available on the College website.