Policy

University Health Network (UHN) is committed to creating a culture where leaders, physicians, staff, learners, volunteers, patients, and families speak up for safety. Safety and eliminating preventable harm to patients and visitors is everyone’s responsibility. UHN will maintain a framework for identification, analysis, management and monitoring of patient safety events and near miss events.

All staff and physicians must:

- report safety events and near miss events using the UHN Incident Reporting & Review eForm as soon as possible following an actual or potential occurrence
- disclose to patients/substitute decision makers (SDMs) in accordance with the Disclosure of Safety Events to Patients policy 3.20.007.

The following types of safety events must be reported:

- issues involving patient care (e.g. medications, falls, infection control-related events, diagnostics, adverse events related to implantable devices or medical equipment, treatment)
- events related to visitors (e.g. falls)
- privacy incidents
- workplace violence events where a patient is harmed or has the potential for harm

All incidents resulting in an injury/illness or potential injury/illness to staff, physicians, learners, volunteers, or agency/contract staff, including workplace violence incidents, must be reported through the online incident reporting portal under the Workplace Safety Event link. (Refer to Accident/Incident Reporting & Investigation policy 6.60.001, Reporting a Critical Injury or Fatality policy 6.60.002, and Violence & Domestic Violence in the Workplace policy 6.30.004 for further details.)

Note: Reviews of safety events are done for quality assurance purposes only. They are done on a confidential basis to ensure full participation of all physicians and staff in the process. Safety event reports contain confidential information and should not be printed and/or distributed with identifiable information. (See Privacy policy 1.40.007.)
All safety events will be managed using the UHN Safety Event Cause Analysis process to ensure a consistent and coordinated approach. This consists of the following phases:

- initiation
- screening
- analysis
- development
- implementation
- sharing
- monitoring

This document contains the following procedures:

- **Patient Safety Events:**
  a. Initiate
  b. Screen
  c. Analyze:
     i. Local Review
     ii. Debrief
     iii. Root Cause Analysis
  d. Develop:
     i. Local Review
     ii. Debriefs
     iii. Root Cause Analysis
  e. Implement:
     i. Local Review/Debrief/Root Cause Analysis
  f. Share:
     i. Local Review/Debrief/Root Cause Analysis
  g. Monitor:
     i. Local Review/Debrief/Root Cause Analysis

- **Workplace Violence Events**
- **Privacy Incidents:**
  a. Staff Member or Physician
  b. Researchers and Patient Notification
  c. Manager of Affected Unit/Department
  d. Privacy Office
Procedures: Patient Safety Events

Notes:

- Listed timelines are for the current phase only. Each time period starts from the end of the previous phase.

- The Implement, Share, and Monitor phases can be done in parallel once the event is reviewed at site Quality of Care Committee (QCC).

Initiate – When a potential patient safety event is identified (0 to 24 hours)

1. **Staff who have identified the potential patient safety event:**
   - Care for the patient and provide for the individual's safety and comfort.
   - Notify the manager/delegate (or site administrator on-call (AOC), if appropriate) where the incident occurred.
   - If the patient has suffered an injury, contact the most responsible physician (MRPh)/most responsible practitioner (MRPr) for assessment.
   - If a visitor has suffered an injury, have a staff member accompany the visitor to the Emergency Department for assessment or call 911.
   - Preserve and secure items, such as:
     - records that typically are not added to the patient health record and/or discarded at the end of shift
     - equipment (e.g. including disposable equipment and tubing, pumps)
     - non-patient care documents that may be relevant to the case (e.g. paging logs, staffing schedules)
   - Complete a safety event report using the UHN Incident Reporting & Review eForm.
   - Bring up potential safety event at the next daily unit huddle.

2. **Physicians who have identified the potential patient safety event:**
   - Assess and care for the patient and provide for the individual's safety and comfort.
   a. Contact the MRPh, if needed.
• Complete a safety event report using the UHN Incident Reporting & Review eForm.

• Complete initial disclosure to patients/SDMs in accordance with Disclosure of Safety Events to Patients policy 3.20.007.

3. **Manager/delegate/MRPh:**
   - Support the patient/family.
   - Support staff/physician/trainee.
   - Confirm that staff have preserved and secured items.
   - Take remedial action, if needed, to ensure safety is established.
   - Ensure that staff/physician has completed an event report using the UHN Incident Reporting & Review eForm.
   - Ensure staff raises safety event at the next daily unit huddle.
   - Raise the safety to director huddle, if appropriate.

4. **Patient safety specialist:** Review all new potential serious safety events (SSEs) reported through the UHN Incident Reporting & Review eForm daily and follow up as appropriate.

**Screen – Determine appropriate safety event review required (24 to 48 hours)**

1. **Clinical director:**
   - Schedule and conduct a SSE screen call/meeting.
   - In partnership with the patient safety specialist, decide which type of safety event review is required based on the likely Safety Event Classification (SEC):
     a. root cause analysis (RCA)
     b. debrief
     c. local review (precursor safety events and near-miss events)
   - If the event will be reviewed at a QCC, indicate that quality of care discussions in the review will be protected under the Quality of Care Information Protection Act (QCIPA).
• Identify review sponsors, lead, and team members.

• Book the RCA or debrief meeting(s).

• Ensure that initial disclosure has occurred in accordance with Disclosure of Safety Events to Patients policy 3.20.007.

2. Patient safety specialist:

• Within 24 to 48 hours of the event, support the initiation of a SSE screen.

• Partner with the clinical director (SSE screen lead) to decide which type of safety event review is required based on the SSE classification.

• Communicate next steps following the outcome of the SSE screen.

Analyze – Conduct safety event review (2 to 4 weeks)

Analyze: Local Review

1. Unit team: Conduct a local review for events that are not SSEs (i.e. near-miss events, precursor safety events).

2. Unit manager:

• Speak with staff to understand what happened, how the individual experienced the error, and why they experienced the error. (See Caring Safely Leadership Module 5.)

• Complete the Manager’s Report section in the UHN Incident Reporting & Review eForm with the findings.

Analyze: Debrief – Event review led by unit leadership

1. Director and medical lead (when appropriate):

• Conduct a safety event debrief using the Standardized Debrief Tool within 14 days of the event being reported.

   Note: The specified turnaround time may not apply in the case of a multi-event review and will be determined on a case-by-case basis.

• Ensure initial disclosure to patient/SDM has occurred according to Disclosure of Safety Events to Patients policy 3.20.007.

• Confirm SEC using the SEC algorithm.
• If the event is an SSE, ensure this is reflected in the “Days since last SSE” indicator for the unit and site, if applicable.

• Notify the patient safety specialist of the confirmed SSE.

• Complete incident review section in the UHN Incident Reporting & Review eForm with the findings from the debrief.

2. **Patient safety specialist:**

• Inform director and escalate if debrief has not occurred within 14 days of the event being reported.
  
  a. Support debrief (as required).

• If the event is a confirmed SSE, incorporate it into the site and UHN Serious Safety Event Rate.

• Add review to site QCC agenda.

**Analyze: Root Cause Analysis – In-depth event review led by patient safety specialist**

1. **Root cause analysis sponsors (clinical director and medical lead):**

• Identify the RCA team.

• Ensure initial disclosure to patient/SDM has occurred according to the Disclosure of Safety Events to Patients policy 3.20.007.

• Schedule all RCA meetings with the RCA team.

• Act as the primary liaison on the RCA for the patient safety specialist.

• Manage the overall quality of the RCA outcomes, e.g. identify correct causes that may have contributed to the event and appropriate corrective actions to prevent recurrence.

2. **Manager/delegate/medical lead:**

• Provide patient safety specialist with names of individuals to participate in RCA 1:1 interviews.

• Communicate priority of participating in these interviews.
3. **Patient safety specialist:**
   - Develop sequence of events.
   - Conduct 1:1 interviews with identified individuals.
     a. Work with the director, Post-Graduate Medical Education; Wightman-Berris Academy, director, Medical Education or senior director, Clinical Education to invite learners.
   - Complete analysis.
   - Identify potential causes that may have contributed to the event.
   - Lead causes meetings in partnership with RCA sponsors to confirm causes that may have contributed to the event, if any.

4. **Staff/physicians:**
   - Participate in RCA 1:1 interviews.
   - Participate in causes meeting, if required.

**Develop – Develop recommendations to address causes (2 to 4 weeks)**

**Develop: Local Review**

1. **Unit team:** Conduct a local review for events that are not SSEs (i.e. near-miss events, precursor safety events).

2. **Manager of area:**
   - Develop local recommendations.
   - Review recommendations with local team.
   - Complete Managers Report section in the [UHN Incident Reporting & Review eForm](#) with the findings.

**Develop: Debriefs**

1. **Clinical director and medical lead:**
   - Develop recommendations for causes identified in debrief.
• Review recommendations at appropriate quality committees for approval.
  a. program/division quality committee
  b. site QCC
  c. UHN QCC
  d. Medical Advisory Committee (MAC)

• Complete recommendation section in the UHN Incident Reporting & Review eForm.

Develop: Root Cause Analysis

1. Patient safety specialist:

• Draft potential recommendations in consultation with key stakeholders.

• Lead recommendations meeting in partnership with RCA sponsors.

• Review RCA and recommendations at appropriate quality committees for approval.
  a. program/division quality committee
  b. site QCC
  c. UHN QCC
  d. UHN Board Safety & Quality Committee
  e. MAC

Implement – Implement recommendations (2 to 3 months)

Implement: Local Review/Debrief/Root Cause Analysis

1. Recommendation owners: Develop, implement, and evaluate corrective actions for causes that may have contributed to the event.

Share – Share root causes and recommendations (2 to 3 months)

Share: Local Review/Debrief/Root Cause Analysis

• Share causes and recommendations with the review teams.

• Complete final disclosure to patient/family/SDM in accordance with Disclosure of Safety Events to Patients policy 3.20.007.

• Share de-identified causes and key learnings more broadly across UHN for learning and to avoid recurrence.
Monitor – Completion and evaluation of recommendations (6 to 12 months)

Monitor: Local Review/Debrief/Root Cause Analysis

1. Appropriate quality committees (e.g. program, site QCC, UHN QCC):
   - Audit completion of recommendations.
   - Review audit results & evaluation findings.
     a. For strategies that are found to be ineffective in addressing the cause, notify recommendations owners and request that new strategies are developed to address the cause.

2. Site and/or UHN QCCs: Evaluate effectiveness of recommendations.

Definitions

Causes/root causes: Identified on a potential rather than conclusive basis.

Medical Advisory Committee (MAC): The group of individuals that is accountable to the Board of Directors in accordance with the Public Hospitals Act. The committee is in place to promote the highest standards of medical care throughout the hospital.

Near miss: An unexpected, unusual or unplanned event where there was a deviation to generally accepted practice standards, but where no harm reached the patient/visitor/staff because the initiating error is caught before it reaches the patient by either a detection barrier built into the process or, sometimes, by chance.

Quality of Care Committee (QCC): A body of one or more individuals that performs quality of care functions designated under the purposes of the Quality of Care Information Protection Act (QCIPA). The activities of a QCC are to study, assess or evaluate the provision of healthcare with a view to improving or maintaining the quality of healthcare including critical incident reviews.

The quality of care information (hereinafter ‘information’) collected and/or discussed by the QCC is protected under the Quality of Care Information Protection Act (QCIPA).

Safety event (formerly known as “incident“): Any unexpected, unusual or unplanned event and/or near miss causing harm or potential harm, to:
   - a patient
   - visitor
• staff
• UHN operations

**Safety Event Classification System:** A coding system which identifies the degree of harm to the patient caused by deviations from generally accepted performance standards (GAPS). The five levels of Serious Safety Events (SSEs) are as follows:

- SSE1 - Death
- SSE2 - Severe Permanent Harm
- SSE3 - Moderate Permanent Harm
- SSE4 - Severe Temporary Harm
- SSE5 - Moderate Temporary Harm

**Serious Safety Event (SSE):** An unexpected, unusual or unplanned event where there was a deviation to generally accepted practice standards, resulting in moderate to severe patient/visitor harm or death. *(Note: Worker safety events are not classified using the SSE classification).*

**UHN Safety Event Cause Analysis:** The review and analysis process used for Serious Safety Events to:

- Learn from safety issues to identify the appropriate system improvements to prevent recurrence
- Create a culture of continuous quality improvement
- Collect and manage data to understand trends that will identify organizational risks

**UHN Serious Safety Event Rate (SSER):** An indicator that measure the aggregate preventable harm across UHN. The SSER is a volume-adjusted measure of Serious Safety Events, those events occurring from a deviation from generally accepted performance standards and resulting in moderate to severe patient harm or death. The SSER is calculated monthly as the number of Serious Safety Events for the previous 12 months per 10,000 adjusted patient days for the same time period.

**Procedures: Workplace Violence Events**

For workplace violence events that do not involve harm or potential harm to patients, see [Violence & Domestic Violence in the Workplace](#) policy 6.30.004.
Procedures: Privacy Incidents

Note: A privacy incident occurs when an agent knows or has reason to believe personal health information (PHI) was collected, used, or disclosed without proper authorization and when PHI is lost or stolen.

Staff Member or Physician

1. Identify scope and contain the incident as much and as quickly as possible.
   - Determine if the incident would allow unauthorized access to any other PHI (e.g. an electronic information system) and take necessary steps to prevent this from recurring (e.g. change passwords and/or ID numbers, and/or temporarily shut down a system).
   - Take steps to contain the incident by stopping the flow of information or retrieving the information.
   - Retrieve hard and/or electronic copies of any PHI that have been disclosed.
   - Ensure that no copies of the PHI have been made and/or retained by the individual who was not authorized to receive the information.
   - Obtain the recipient’s contact information for potential follow-up, if required.
   - If the incident involves a fax:
     a. Cancel the fax as soon as possible.
     b. If a fax was successfully sent to the wrong healthcare provider (e.g. doctor, nurse, or other healthcare provider), ask the provider to confirm shredding of the pages.
     c. If a fax was sent to a recipient who is not a healthcare provider (e.g. member of the public), retrieve the pages by sending a courier or picking up the paper.
   - If the incident involves an email:
     a. Delete the email if still in the outbox.
     b. Recall the email and opt for notification of recall success.

Note: To do this, open the email from the ‘Sent Items’ folder, select ‘Actions’, select ‘Recall This Message’, and check box ‘Tell me if
recall succeeds or fails for each recipient’.

c. If an email cannot be recalled successfully, request that the recipient confirm deletion of the email from all folders (i.e. both Inbox and Deleted Items folders).

- **If the incident involves other types of media (e.g. electronic devices, papers, etc.):**
  
  a. Search for papers and devices, and request help (from Housekeeping, Security, and/or report lost or stolen media to police, etc.) if necessary.
  
  b. Lock up remaining papers and devices at risk.

2. Notify the area manager.

3. For moderate, severe, or critical incidents, notify the Privacy Office.

- After hours, for critical/severe/moderate incidents, contact the site AOC.

4. Submit an incident report via the UHN Incident Reporting & Review eForm, classify the incident as ‘Privacy,’ and classify the type of privacy incident based on the following criteria:

- **Near miss:** Incident identified, patient(s) not impacted.

- **Minor:** Involves identifiable PHI and/or corporate confidential information (CCI) and at least one of the following:
  
  a. 1 to 10 individuals have been impacted
  b. no risk of intentional harm to individual(s)

- **Moderate:** Involves identifiable PHI and/or CCI and at least one of the following:
  
  a. 11 to 50 individuals have been impacted
  b. minimal risk of intentional harm to individual(s)

- **Severe:** Involves identifiable PHI and/or CCI and at least one of the following:
  
  a. 51 to 100 individuals have been impacted
  b. suspected risk of intentional harm to individual(s)
• **Critical:** Involves identifiable PHI and/or CCI and at least one of the following:
  a. more than 100 individuals have been impacted
  b. proven risk and/or confirmed case of intentional harm to individual(s)

**Notes:**

• For incidents that could fit under more than one classification, select the more serious classification (e.g. if an incident affects 5 patients but there is a suspected risk of intentional harm, classify the incident as severe, not minor).

• “Intentional harm” means PHI will be deliberately be used in an inappropriate manner (e.g. to publicize information, embarrass a patient or to sell the information).

5. For moderate, severe or critical incidents, use the Incident Management Checklist found in Appendix A of the UHN Protocol for Managing Privacy Incidents for guidance.

6. Consult with the Privacy Office regarding patient notification.

**Note:** Only send patient notifications in an event of a breach if:

• Privacy Office has recommended a notification
• content and method of the notification has been vetted by the Privacy Office

7. Engage in investigation and remediation activities, as instructed by the area manager/AOS.

**Researchers and Patient Notification**

1. **Researchers:** Contact the Research Ethics Board (REB) and Privacy Office for next steps prior to notifying patients in an event of a suspected or confirmed privacy breach.

**Manager of Affected Unit/Department**

1. Notify relevant UHN departments (e.g. Patient Relations, Legal Affairs).

2. Complete incident reporting & review processes.

3. Oversee and ensure containment and remediation.

4. Support personnel responsible for incident.
5. Work through tasks in the Incident Management Checklist found in Appendix A of the UHN Protocol for Managing Privacy Incidents.

6. Where the manager and/or the Privacy Office deems appropriate, conduct additional review or investigation such as:
   - review the circumstances surrounding the incident
   - review the adequacy of existing policies and procedures in protecting PHI
   - organizational/departmental training, education review
   - an audit

7. Consult with the Privacy Office regarding patient notification.

   **Note:** Only send patient notifications in an event of a breach if:
   - Privacy Office has recommended a notification
   - content and method of the notification has been vetted by the Privacy Office

**Privacy Office**

1. Provide guidance in managing containment and remediation.

2. Provide guidance on notification plan and materials.

3. Notify the chief legal officer and/or the Office of the Information and Privacy Commissioner (IPC) of new incidents, and provide updates about active incidents.

4. Notify police in appropriate circumstances.
Appendix A: How to Complete a Safety Event Report

Completing an Incident Report

Safety Event Portal

Use this portal to report a Safety Event at UHN.

Policy Number 3.20.005
Section Medical/Legal/Clinical Ethics
Original Date 08/91
Revision Dates 10/99; 09/00; 11/01; 01/06; 09/11; 10/11; 01/12; 06/14; 09/19
Issued By Quality & Safety
Review Dates
Approved By Vice-president, Patient Experience & Chief Health Professions; Medical Advisory Committee
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How to Report?

Answer the following questions:

1. What happened, to whom and when?

2. What was the impact?
   - Extent of injury (e.g., cut, bruise, none?)
   - Procedure completed, aborted or rescheduled?

3. What was the response?
   - If patient was assessed and monitored describe how
   - Who was notified (e.g., referring MD, Pharmacy?)
   - What instructions were provided to the patient?
   - Allergy alert flagged in EPR for next visit?

Be brief and factual.
No emotion, names, blame.
Do not refer to previous incidents.

UHN Incident Workflow

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Appendix B: Safety Event Classification

Safety Event Classification Algorithm

- Was there a deviation from generally accepted performance standards (GAPS)
  - Yes
  - Did the deviation reach the patient/worker?
    - Yes
      - Did the deviation cause moderate or severe harm or death?
        - Yes
          - Serious Safety Event
        - No
          - Near Miss Safety Event
    - No
      - Not a Safety Event
  - No
    - Precursor Safety Event
### Safety Event Classification Levels of Harm

<table>
<thead>
<tr>
<th>Code</th>
<th>Level of Harm</th>
<th>Patient Harm Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSE 1</td>
<td>Death</td>
<td>A deviation in GAPS resulting in death</td>
</tr>
<tr>
<td>SSE 2</td>
<td>Severe Permanent Harm</td>
<td>A deviation in GAPS resulting in critical, life-changing harm with no expected change in clinical status; includes events resulting in permanent loss of organ, limb, or vital physiological or neurologic function</td>
</tr>
<tr>
<td>SSE 3</td>
<td>Moderate Permanent Harm</td>
<td>A deviation in GAPS resulting in significant harm with no expected change in clinical condition yet not sufficiently severe to impact activities of daily living or business functioning; includes events that result in permanent reduction in physiologic reserve, disfigurement, and impaired or aided sense of function</td>
</tr>
<tr>
<td>SSE 4</td>
<td>Severe Temporary Harm</td>
<td>A deviation in GAPS resulting in critical, potentially life-threatening harm yet lasting for a limited time with no permanent residual; requires prolonged transfer to a higher level of care/monitoring, transfer to a higher level of care for a life-threatening condition, or an additional major surgery, procedure, or treatment to resolve the condition</td>
</tr>
<tr>
<td>SSE 5</td>
<td>Moderate Temporary Harm</td>
<td>A deviation in GAPS resulting in significant harm lasting for a limited time; requires a higher level of care/monitoring or an additional minor procedure or treatment to resolve the condition</td>
</tr>
</tbody>
</table>
Safety Event Classification Pyramid

A deviation from generally accepted performance standards (GAPS) that...

**Serious Safety Event**
- Reaches the patient or employee and
- Results in moderate harm to severe harm or death

**Precursor Safety Event**
- Reaches the patient or employee and
- Results in minimal harm or no detectable harm

**Near Miss Safety Event**
- Does not reach the patient or employee
- Error is caught by a detection barrier or by chance
Appendix C: Root Cause Analysis Process

UHN Root Cause Analysis Process

ALL EVENTS
- Potential serious safety event is reported

INITIATE (0-12 hrs)
- STABILISE SITUATION
  - Manager or delegate:
    - Preserve items
    - Support patient/family/staff
    - Take remedial action if needed
    - Ensure event reported

SCREEN (24-48 hrs)
- SSE SCREEN CALL/EMAIL
  - Determine:
    - Potential SSE classification
    - Level of analysis
    - Analysis team members
    - Next steps

Meets criteria for RCA?
- YES: Complete RCA
- NO: Complete Debrief

ROOT CAUSE ANALYSIS

ANALYSE (2-4 weeks)
- SEQUENCE OF EVENTS
  - Patient Safety Specialist:
    - Develop sequence of events
    - Gather other data as needed

- ANALYSIS OF EVENT
  - Patient Safety Specialist:
    - Select analytic tool(s)
    - Complete event analysis

- CAUSES MEETING(s)
  - Confirm sequence of events
  - Confirm results of analysis
  - Review potential root causes

DEVELOP (2-4 weeks)
- RECOMMENDATIONS MEETING(s):
  - Confirm root causes
  - Develop recommendations

- RECOMMENDATION CO-DESIGN WORKSHOP
  - Engage frontline staff & key stakeholders
  - Conceptualize corrective actions
  - Test & validate corrective actions

- RECOMMENDATION APPROVAL
  - Review at unit/program/site/ UHN GCC as needed

IMPLEMENT (2-3 months)
- LOCAL RECOMMENDATIONS
  - Engage key stakeholders
  - Develop implementation plan
  - Implement recommendations

SYSTEMIC RECOMMENDATIONS
- Engage key stakeholders as determined by UHN GCC
  - Develop implementation plan
  - Implement recommendations

MONITOR (2-3 months)
- AUDIT
  - Complete audit(s) of effectiveness & sustainability of recommendations
  - Review and act on audit results

SHARE (3-6 months)
- SHARE LEARNINGS
  - Share RCA learnings with patient/family & staff

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<td>Quality &amp; Safety</td>
<td>Review Dates</td>
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<td>Approved By</td>
<td>Vice-president, Patient Experience &amp; Chief Health Professions; Medical Advisory Committee</td>
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Appendix D: Standardized Debrief Tools

Pre-Debrief Checklist – Manager

Immediately following the Event

☐ Secure any equipment or supplies involved in the event.

☐ Complete remedial actions as necessary to reduce possibility of immediate recurrence in other areas.

Scheduling a Debrief

☐ Work with clinical director and administrative assistant to schedule debrief, (within 2 weeks of event being reported).

☐ Provide list of debrief participants to clinical director and administrative assistant. Participants should include:

  ▪ Clinical director (chair)
  ▪ Program medical director/division heads
  ▪ Most responsible physician
  ▪ Manager of the area
  ▪ Patient safety specialist (PSS)
  ▪ Professional Practice
  ▪ Subject matter experts (e.g. Joint Department of Medical Imaging, Laboratory Medical Program, pharmacy, Hospital Acquired Conditions* representative etc.)
  ▪ Patient Relations
  ▪ Other as appropriate

If the participants cannot attend, request that a delegate be sent in their place.

For events relating to HAC’s please (Refer to Resources and Tools A)

Preparing for a Debrief

Please complete the following before the debrief:

☐ Document the Sequence of Events that led up to the event. (Refer to Resources and Tools B.)

☐ Interview all involved in the event and confirm sequence of events. (Resources and Tools C & D.)

☐ Consult taxonomy charts to explore potential Individual and System Failure Modes to guide your interview questions. (Refer to Resources and Tools E & F – from Module 5.)
- Determine what information was disclosed to the patient and/or family and by whom.
- Connect with patient relations to determine if patient/substitute decision maker (SDM) interview is required as per QCIPA.
- Pre-circulate sequence of events to those attending the debrief.
- Prepare summary of event for debrief.
- At any point connect with the site Patient Safety Specialist for assistance.

For all communication that includes information regarding specifics of the events or supporting information please include in the email subject line “Quality of Care Information - Privileged and Confidential“

**Tools & Resources**

**HAC Specific Considerations**

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<tr>
<th>HAC</th>
<th>Debrief Participants</th>
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<tr>
<td>Adverse Drug Events</td>
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<tr>
<td>Central Line Infections</td>
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<td>C. Difficile</td>
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<td>Falls</td>
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<td>Pressure Injuries</td>
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<tr>
<td>Surgical Site Infections</td>
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</tbody>
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**Sequence of Events**

<table>
<thead>
<tr>
<th>Date / Time</th>
<th>Event/Action</th>
<th>Source (e.g., EPR, paper chart, interview)</th>
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<tbody>
<tr>
<td>1.</td>
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<td>6.</td>
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</tbody>
</table>
Interview Questions Guide

1. Open ended and broad questions:
   - Tell me what happened…

2. More close ended, specific questions:
   - What time did the physician arrive?
   - Do you recall what the pharmacist told you?
   - Do you remember what you were thinking or doing when this occurred?
   - Do you recall anything unusual about the shift or event?

3. Finish with broad questions, again probing for judgments
   - Why do you think that happened?
   - Are there any barriers that keep you from doing this correctly?
   - Anything else you recall?
   - Is there anyone else I should talk to about this event?
   - What would you suggest to prevent or improve?
Events Analysis Worksheet

<table>
<thead>
<tr>
<th>Incident ID #:</th>
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</thead>
<tbody>
<tr>
<td>4) Why did they experience the error (system failure mode)</td>
</tr>
<tr>
<td>and...</td>
</tr>
<tr>
<td>3) How did they experience the error (individual failure mode)</td>
</tr>
<tr>
<td>because...</td>
</tr>
<tr>
<td>2) What went wrong...</td>
</tr>
<tr>
<td>1) Who START</td>
</tr>
</tbody>
</table>

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Taxonomy of Individual Failure Modes
Taxonomy of System Failure Modes

Debrief Guidelines

The debrief will be facilitated by the Clinical Director or delegate, and proceed as follows:

Introduction (5 min)

1. To start the debrief, set the tone/ground rules, QCIPA applied if reviewed at QCC.

Notes:

a. The purpose of the debrief is for quality improvement, to learn from the event, and to suggest changes to prevent similar incidents from happening in the future.

b. We recognize that safety events are often a result of system/process issues, and seldom the fault of one individual.
c. We promote a fair and just safety culture, so that everyone can feel comfortable sharing their thoughts, ideas and concerns.

d. Please remember that everything discussed in this meeting is confidential and for the purposes of quality improvement.

2. Complete a round of introductions

Summary of Event (10 min)

The staff member with most knowledge about the patient will be required to present a summary of the event (refer to Sequence of Events table), and debrief participants to confirm information is accurate.

- Why patient admitted
- What happened
- Harm to patient
- Disclosure to patient
- Patient or substitute decision maker to be offered an interview as part of the review process for severe and critical safety events

Deviations (15 min)

The group will determine if there were deviations from generally accepted performance standards (GAPS), including best practice standards internal and external to UHN.

- What care do we expect to see (generally accepted performance standards)
- What care didn’t we see (deviations)

Recommendations (15 min)

The group will then determine what recommendations to put in place to prevent recurrence and assign:

- Owner
- Target completion date

Level of Harm as per HPI Safety Event Classification (5 min)

The facilitator and/or the patient safety specialist will walk through the HPI Safety Event Classification Algorithm with the group to confirm level of harm.
Conclusion

1. Wrap up: Determine if further investigation is required.

2. Remind the participants that summary of event, contributing factors and recommendations will go to site and UHN QCC if deemed an SSE 1-5.

Debrief Summary

<table>
<thead>
<tr>
<th>Event ID:</th>
<th>Event Type:</th>
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<table>
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<tr>
<th>Event Date:</th>
<th>Date of Debrief:</th>
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<table>
<thead>
<tr>
<th>Director:</th>
<th>Unit Manager:</th>
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</table>

1. Summarize the event (What happened? What was the outcome?).

Complete prior to debrief

Why was patient admitted to hospital? (Admitting diagnosis, past medical history)

What happened?

Document detailed timeline in the Sequence of Events table.

What was the outcome to the patient?
What was disclosed to patient? Was patient relations involved?

What were the immediate and remedial actions taken? (What actions were taken to address conditions adverse to quality in the area where the event occurred?)


State in the format as who did/did not do what because why. (Refer to Events Analysis Worksheet)

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<td>5.</td>
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</table>

3. Identify recommendations for improvement. Complete during debrief

<table>
<thead>
<tr>
<th>Recommendation(s)</th>
<th>Owner</th>
<th>Target Completion Date</th>
</tr>
</thead>
<tbody>
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<td>4.</td>
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</table>
4. Determine level of Harm using HPI Safety Event Classification Quick Reference Guide

Post-Debrief Checklist – Manager

❖ The summary of event, contributing factors, and recommendations will be presented at site and UHN Quality of Care Committees (QCC). Please complete the following to facilitate this process.

☐ Complete the “Review Section” in the eForm and include (within 1 week of debrief):
  ☐ Summary of event with additional details from debrief
  ☐ Contributing Factors
  ☐ Recommendations

☐ Prepare the “Safety Event” presentation slide deck for site QCC in consultation with Patient Safety Specialist

☐ Keep staff appraised of recommendations generated from site and UHN QCC

For all communication that includes information regarding specifics of the events or supporting information please include in the email subject line "Quality of Care Information - Privileged and Confidential."
Appendix E: Quality of Care Information and Protection Act (QCIPA)

QCIPA Overview

QCIPA recognizes “that health care providers and other staff in health facilities sometimes need to hold confidential discussions to identify and analyze errors affecting patients, systemic problems and opportunities for quality improvement in patient health care.” The Act further outlines that “protections are needed to encourage and enable healthcare providers and other staff of health facilities to share all available information, provide honest assessment and opinions and participate in discussions to improve patient health care without fear of retaliation.” (QCIPA, Preamble)

Therefore, QCIPA provides broad statutory protections to those who participate in the mechanism of a quality review process under the legislation. Under QCIPA there is assurance that protected discussions may not be used in an adversarial manner in collateral proceedings, professional regulatory complaints and/or civil suits.

What is Protected?

QCIPA provides the following protections with respect to quality of care information that is provided to a Quality of Care Committee:

- Quality of Care Information is inadmissible as evidence in a civil proceeding or a matter before a tribunal or regulatory health college. (QCIPA, s. 10)

- No person may be dismissed, demoted, disciplined, or otherwise disadvantaged by reason that they have disclosed information to a quality of care committee. Every person or corporation who contravenes this section is guilty of an offence and subject to a fine. (QCIPA, ss. 11 and 12)

- No action or other proceeding may be instituted against a person who in good faith discloses information to a quality of care committee at the request of the committee or for the purposes of assisting the committee to carry out its quality of care functions. (QCIPA, section 13)

- Persons who disclose quality of care information in contravention of the Act are guilty of an offence and subject to fines. (QCIPA, s. 12)
What is Quality of Care Information?

“Quality of care information” means information that,

(a) is collected or prepared by or for a quality of care committee for the sole or primary purpose of assisting the committee in carrying out its quality of care functions,
(b) relates to the discussions and deliberations of a quality of care committee in carrying out its quality of care functions, or
(c) relates solely or primarily to any activity that a quality of care committee carries on as part of its quality of care functions, including information contained in records that a quality of care committee creates or maintains related to its quality of care functions. (QCIPA, section 2(2))

What is not included?

“Quality of care information” does not include any of the following:

1. Information contained in a patient record.
2. Information contained in a record that is required by law to be created or to be maintained.
3. Information relating to a patient in respect of a critical incident that describes,
   - facts of what occurred with respect to the incident,
   - what the quality of care committee or health facility has identified, if anything, as the cause or causes of the incident,
   - the consequences of the critical incident for the patient, as they become known,
   - the actions taken and recommended to be taken to address the consequences of the critical incident for the patient, including any health care or treatment that is advisable, or
   - the systemic steps, if any, that a health facility is taking or has taken in order to avoid or reduce the risk of further similar incidents.
4. Information that consists of facts contained in a record of an incident involving the provision of health care to a patient. (QCIPA, section 2(3))