Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg — Caring for Health / À l'écoute de notre santé **POLICY DRAFT**	**REGIONAL** Applicable to all WRHA governed facilities and Sites (including hospitals and personal care homes), and all funded hospitals and personal care homes. All other funded entities are excluded unless set out within a particular Service Purchase Agreement.		Level **1**
	Policy Name: **Critical Incident Reporting and Management**	Policy Number: 10.50.040	Page: 1 of 5
	Approval Signature: *Original signed by A. Wilgosh*	Section: GENERAL ADMINISTRATION	
	Date: April 2014	Supercedes: March 2014	

1.0 **PURPOSE:**

1.1 To provide direction regarding the reporting and management of Critical Incidents.

1.2 To reduce the risk of Patient harm by promoting learning from Critical Incidents.

1.3 To fulfill the responsibilities as outlined in the *Regional Health Authorities Act*.

2.0 **DEFINITIONS**:

2.1 Critical Incident: As set out in the Regional Health Authorities Act, means:

An unintended event that occurs when health services are provided to a Patient and result in a consequence to him or her that:

2.1.1 is serious and undesired, such as death, disability, injury, or harm, unplanned admission to hospital or unusual extension of a hospital stay, and;

2.1.2 does not result from the Patient's underlying health condition or from a risk inherent in providing the health services.

2.2 Critical Incident Review Committee: a committee formed for the purpose of reviewing a Critical Incident.

2.3 Disclosure: an ongoing process that includes sharing information (as outlined in 4.2.2) with the Patient or Persons Permitted to Exercise the Rights of an individual about the care provided, as well as responding to questions.

2.4 Patient: refers to persons receiving health care services within the Winnipeg-Churchill health region.

2.5 Persons Permitted to Exercise the Rights of an individual: in accordance with the Personal Health Information Act is defined as:

The rights of an individual under this Act may be exercised:
(a) by any person with written authorization from the individual to act on the individual's behalf;
(b) by a proxy appointed by the individual under The Health Care Directives Act;
(c) by a committee appointed for the individual under The Mental Health Act if the committee has the power to make health care decisions on the individual's behalf;
(d) by a substitute decision maker for personal care appointed for the individual under The Vulnerable Persons Living with a Mental Disability Act if the exercise of the right relates to the powers and duties of the substitute decision maker;
(e) by the parent or guardian of an individual who is a minor, if the minor does not have the capacity to make health care decisions, or;
(f) if the individual is deceased, by his or her personal representative.

If the trustee reasonably believes that no person listed in clauses (a) to (f) exists or is available, the adult person listed first in the following clauses who is readily available and willing to act may exercise the rights of an individual who lacks the capacity to do so:
(g) the individual's spouse, or common-law partner, with whom the individual is cohabiting;
(h) a son or daughter;
(i) a parent, if the individual is an adult;
(j) a brother or sister;
(k) a person with whom the individual is known to have a close personal relationship;
(l) a grandparent;
(m) a grandchild;
(n) an aunt or uncle;
(o) a nephew or niece.

Ranking: The older or oldest of two or more relatives described above is to be preferred to another of those relatives.

2.6 Site: includes funded healthcare facilities in all sectors, Community Areas, programs, departments, and services within the Winnipeg-Churchill health region.

2.7 Staff: all persons employed within the Winnipeg-Churchill health region, including members of the medical staff, physicians, volunteers, board members, students, and other individuals associated through legal contracts.

3.0 POLICY:

3.1 Staff observing or involved in a Critical Incident shall follow the procedures for reporting as outlined in this policy and Site operating procedures.

3.2 Individuals (other than Staff or Patients) who observe a Critical Incident shall be encouraged to report it in the manner outlined in this policy and its procedure.

3.3 With the goal of encouraging a culture of reporting and applied learning, the Winnipeg-Churchill health region shall facilitate Staff, Patients and individuals to report Critical Incidents.

3.4 Sites shall establish operating procedures that comply with the reporting, Disclosure, monitoring, review, and follow-up arising from Critical Incidents, in consultation with the WRHA Quality Improvement and Patient Safety Unit.

4.0 PROCEDURE:

4.1 REPORTING OF CRITICAL INCIDENTS:

4.1.1 Critical Incidents are reported by contacting the WRHA telephone line or online using RL6: Risk, within 24 hours upon learning of the Critical Incident. Callers may choose to report anonymously. Information about the WRHA telephone line, including the telephone number, can be found at http://www.wrha.mb.ca/healthinfo/patientsafety/criticalincident/index.php.

4.1.2 Staff report Critical Incidents to their immediate supervisor or Site designate.

4.1.3 The WRHA Quality Improvement and Patient Safety Unit ensures an e-mail alert is sent to the appropriate recipients.

4.2 MANAGEMENT OF CRITICAL INCIDENTS:

4.2.1 An immediate supervisor or Site designate ensures:

4.2.1.1 Patients, Staff and individuals are safeguarded and receive immediate clinical care as needed.

4.2.1.2 The location of the event including pertinent equipment and supplies is secured if necessary. For example, in the case of an unexpected death. This could include but is not limited to ensuring equipment is not removed from the scene or altered in any way, and securing records, including all relevant medical records, if applicable. In the case of death, follow the steps as outlined in the Step By Step Instructions for Completion of the Death Documentation Package found on WRHA Insite at http://home.wrha.mb.ca/hinfo/index.php.

4.2.1.3 A person has been designated to offer ongoing contact and support for the Patient and family members;

4.2.1.4 Disclosure occurs as required in the *Regional Health Authorities Act and*

the Manitoba Health Critical Incident policy, and as described in 4.2.2 below;

4.2.1.5 A completed WRHA Disclosure record is faxed to the WRHA Intake Coordinator with the original copy placed in the Patient record;

4.2.1.6 There is ongoing support for the Staff member(s) involved;

4.2.1.7 Any student involved contacts his/her supervisor for support;

4.2.1.8 The Site insurer is notified when appropriate;

4.2.1.9 A review is completed through the appointment of a Critical Incident Review Committee;

4.2.1.10 Within 88 business days of reporting the Critical Incident, a copy of the written final report is sent to the WRHA Intake Coordinator, and;

4.2.1.11 Follow-up actions and recommendations arising from Critical Incident reviews are monitored and analyzed for the purpose of applied learning and system improvements.

Information is documented on a Critical Incident Disclosure record at http://home.wrha.mb.ca/patientsafety/documents/PSDisclosureRecord2011.pdf.

4.2.2 Staff designated by the Site who are involved in Disclosure discussions provide the Patient or Persons Permitted to Exercise the Rights of an individual with:

4.2.2.1 the facts of what actually occurred with respect to the Critical Incident;

4.2.2.2 its consequences for the individual as they become known;

4.2.2.3 the actions taken and to be taken to address the consequences of the Critical Incident, including any health services, care or treatment that are advisable;

4.2.2.4 an expression of regret that the event occurred, and;

4.2.2.5 the Disclosure record to be examined and copied for the individual at no cost.

4.2.3 The WRHA designate ensures Manitoba Health receives:

4.2.3.1 initial notification of the Critical Incident within 24 hours;

4.2.3.2 a written status report within 30 business days;

4.2.3.3 a copy of the final report within 90 business days, and;

4.2.3.4 a supplementary report on the status of the implementation of the Final Report recommendations, no later than 90 business days after submission of the final report.

5.0 REFERENCES:

5.1 Accreditation Canada. Qmentum Standards. Retrieved November 5, 2012 at http://www.accreditation.ca/accreditation-programs/qmentum/standards/.

5.2 Canadian Institute for Health Information. Retrieved June 10, 2012 from the World Wide Web: http://www.Critical Incidenthi.ca.

5.3 Canadian Patient Safety Institute. Retrieved June 10, 2012 from the World Wide Web: http://www.patientsafetyinstitute.ca.

5.4 Institute for Healthcare Improvement. Retrieved June 10, 2012 from the World Wide Web: http://www.patientsafetyinstitute.ca.

5.5 Kohn, L.T., Corrigan, J.H. and Donaldson, M.S. Institute of Medicine. Washington, DC National Academy Press 2000. To Err is Human: Building a Safer Health System.

5.6 *The Regional Health Authorities Act* (2006, May 3). Winnipeg, Manitoba: Manitoba Health. Retrieved November 5, 2012 from the World Wide Web: http://web2.gov.mb.ca/bills/38-3/b017e.php

5.7 WRHA. *Access to Personal Health Information* policy (10.40.040) at http://home.wrha.mb.ca/corp/policy/files/10.40.040.pdf.

5.8 Manitoba Health. *Critical Incident Reporting and Management* policy (HCS 200.2). May 20, 2010.

5.9 *The Apology Act* (October 9, 2008). Winnipeg, Manitoba. Retrieved March 23, 2013 from the World Wide Web at http://web2.gov.mb.ca/laws/statutes/ccsm/a098e.php.

5.10 Critical Occurrence Reporting and Management #10.50.045 http://home.wrha.mb.ca/corp/policy/policy.php

5.11 Occurrence, Near Miss Reporting & Management #10.50.020 http://home.wrha.mb.ca/corp/policy/policy.php

***Policy Contact**:* Kim Warner, BA, MSW, CHE
WRHA Director of Operations, Patient Safety,
Quality Improvement & Patient Safety Unit