Purpose

To outline a reporting system that promotes client safety by learning from experiences and utilizing the results of investigations and data analysis to prepare and disseminate recommendations for system improvements.

Scope

All Acclaim Health employees, students and volunteers are accountable for reporting sentinel, adverse, and near miss events. Directors, managers, supervisors and coordinators are responsible for investigating these events.

Definitions

“Client” refers to an individual receiving service or an external stakeholder (ex: donor).

“Client Safety” is the process of reducing unsafe acts within the continuum of care by utilizing best practices that lead to the most favourable client outcomes.

“PDSA Framework” is the Plan-Do-Study-Act (PDSA) that is used for testing change by planning it, trying it, observing the results, and acting on what is learned.

“Root Cause Analysis” is an analytical tool that includes cause and effect relationships, used to complete a comprehensive, system-based review of an event.

“Reporting” is the communication of information by an employee about a sentinel event, adverse event or near-miss, through appropriate internal processes, in order to reduce the risk of reoccurrence.

“Harm” is an outcome that negatively affects the client’s health and/or quality of life.

“Sentinel Event” is an unexpected event related to a system or process deficiency which leads to death or a major loss of function of a sensory, motor, physiological or psychological nature that was not present before the event, is not related to an underlying medical condition, and lasts a minimum of 2 weeks. These events are Code 3 based on the risk impact assessment.
  - Example: Loss of consciousness causing respiratory arrest, substantial blood loss causing shock, amputation or fracture of a leg or arm, major burn, loss of sight, adverse drug reaction requiring hospitalization, client elopement where the client is not known to be missing. See additional examples from Accreditation Canada (Appendix A).
“Adverse Event” is an event related to the care and/or service provided to the client that causes a harmful or unfavourable result that is unintended, unexpected, or unplanned and is not related to the client’s underlying medical condition. These events can be a Code 3, Code 2 or Code 1 based on the risk impact assessment.

- Example: Fall, medication/procedure errors, infection control issues (break in sterile technique), client complaints, privacy breach.

“Near Miss” is an event that has the potential to cause harmful or unfavourable results and unexpected death BUT did not happen due to timely intervention.

- Example: Wrong amount of narcotic drawn up but not given because the error is caught before administration.
- Client who opens a door to elope but staff notice the client’s actions and intervene by redirecting the client.
- A hazard that may pose a safety risk for a client.

“Occurrence” is an event that may or may not be client related BUT is not related to a client sentinel, adverse, or near miss event.

- Example: A client billing issue, an unwitnessed client event such as a fall when the worker is not on duty, a witnessed abuse of a non-client.

“Witnessed Event” means that at the time of the event an Acclaim Health staff was in the same general area as the client BUT may not have seen the event.

- Example: Client falls in the bathroom but the staff person is in the bedroom.

“Unwitnessed Event” means that at the time of the event an Acclaim Health staff was not in the same area as the client.

- Example: Client found on floor when worker arrives in the home.
- Example: Client reports a fall that occurred overnight when no workers were present.

Policy

Acclaim Health has adopted the Ontario Health Quality Council Model for Improvement as the model for examining quality improvements that are the result of sentinel, adverse, or near-miss events. The model examines what happened, why the event occurred, and how to prevent it from happening again. One of the components of this model is the PDSA framework used to collect data, investigate the root cause based on the likelihood and impact of the event, put into place a change to address the root cause, measure the results of the change and implement the change if it successfully improves client safety.
One of the key components of the Model for Improvement is a reporting system that enhances client safety by promoting a “no blame” approach to reporting, encourages constructive response based on the results of data analysis, and endorses the communication of lesson-learned throughout the organization. All employees are responsible to report to a supervisor an event that develops into a sentinel or adverse event as well as a near-miss.

The Director of Quality Improvement is responsible for ensuring that all events are investigated appropriately within the established timeline and according to the impact of the event.

Consequences

All employees and volunteers are accountable for reporting and documenting a client event within the timelines established. Failure to do so will result in progressive disciplinary action up to and including termination of employment.

Procedure

1.0 Sentinel Event

1.1. The employee, student and volunteer will call 911 (where applicable) before calling the supervisor.

1.2. Employees/students will verbally report the event to their direct supervisor or on-call supervisor immediately at the time of the event.

1.3. Volunteers will report

- During Business Hours: The volunteer will verbally report the event to their coordinator immediately at the time of the event. If the coordinator cannot be reached, the call will be taken by another coordinator in the office.
- After Business Hours: A CSS volunteer will immediately call the Answering Service who will page the on-call supervisor. The on-call supervisor will contact the Director of Community Support Services or designate.
- An Alzheimer Services Support and Education volunteer will contact the Education Coordinator by cell phone.

1.4. The supervisor will collect the information on the Sentinel, Adverse Event Report.

1.5. The supervisor will notify their Director immediately who in turn will notify the CEO or designate immediately.
1.6. The CEO and Director will jointly investigate the event using root cause analysis within the context of the PDSA framework within 1 business day. A preliminary action plan will be developed for the employee or volunteer.

1.7. The initial disclosure of the event will be made face-to-face by the CEO (or designate) and Director and the employee, student or volunteer, if appropriate, with the client and/or caregiver (Refer to Disclosure of Sentinel and Adverse Events policy).

1.8. Further disclosure can be made with the client and/or caregiver once the investigation has been completed.

1.9. The Supervisor and Director will arrange a face-to-face meeting with the employee, student or volunteer as per the timelines in the action plan to provide support and ensure that all action plan items have been addressed.

1.10. If restrictions have been placed on a Health Services employee, the Health Services Supervisor will notify the Client Service Coordinator. If restrictions have been placed on other employees the supervisor will manage their schedule. If restrictions have been placed on a student or volunteer, the supervisor will alter their activities as needed.

1.11. The Director of Quality Improvement will collaborate with Directors to ensure that appropriate verbal and written communication is completed with employees, students and volunteers regarding actions taken to prevent reoccurrence.

1.12. The Director of Quality Improvement will notify the Quality Council and Leadership team of the root cause(s) and action plan at their next meeting. The CEO will notify the Board.

1.13. The Director of Quality Improvement will track all sentinel events and will provide to Accreditation Canada a summary of sentinel events from date of last on-site visit to one year prior to the next on-site survey.

1.14. This summary will contain:
   - Date of the event
   - Location (name of site) and/or services where the event occurred
   - Nature of the event (using the examples provided by Accreditation Canada in Appendix A or definitions listed above)
   - Event follow-up status
1.15. The Director of Quality Improvement will upload the Sentinel Event Summary onto the Accreditation Canada Client Portal one year prior to the on-site survey.

2.0 **Adverse Event**

2.1 **Employee/Student Reporting:** The employee/student will verbally report the event to their direct supervisor or on-call supervisor **within 4 hours** from the time of the event.

2.2 **Volunteer Reporting:**

- During Business Hours: The volunteer will verbally report the event to their coordinator **within 4 hours** of the event. If the coordinator cannot be reached, the call will be taken by another coordinator in the office.
- After Business Hours: The volunteer will call the Answering Service within 4 hours of the event. The Answering Service will page the on-call supervisor. The on-call supervisor will contact the Director of Community Support Services or designate.
- An Alzheimer Services Support and Education volunteer will contact the Education Coordinator by cell phone.

2.3 The supervisor will investigate the event and document the information on the Client Sentinel, Adverse Event Report. The Supervisor will speak with all parties involved in the event. If the client has since been discharged, all efforts will be made to locate and speak with the client. Consent to interview the client will be required.

2.4 The supervisor will investigate the event using root cause analysis within the context of the PDSA framework as follows: **Code 3 within 1 business day; Code 2 within 3 business days; Code 1 within 5 business days.** A preliminary action plan will be developed for the employee or volunteer.

2.5 The initial disclosure of the Code 3 or Code 2 events will be made by telephone by the Supervisor and employee, student or volunteer, if appropriate, with the client and/or caregiver. A face-to-face meeting will be arranged at the request of the client or caregiver. A Code 1 event disclosure will be done at the discretion of the Supervisor and or Director/Manager. There may be situations where the initial disclosure will occur face-to-face at the time of the event. Example: Nurse realizes she gave incorrect dose of a medication. (Refer to Disclosure of Sentinel and Adverse Events policy).

2.6 Further disclosure can be made with the client and/or caregiver once the investigation has been completed.

2.7 The Supervisor is responsible for updating the Client Sentinel Adverse Event report once the investigation and disclosure is completed.
2.8 The Supervisor and Director/Manager will arrange a face-to-face meeting with the employee, student or volunteer as per the timelines in the action plan to provide support and ensure that all action plan items have been addressed.

2.9 The Supervisor will communicate the action plan to other employees if applicable.

2.10 If restrictions have been placed on a Health Services employee, the Supervisor will notify the Client Services Coordinator. If restrictions have been placed on other employees the supervisor will manage their schedule. If restrictions have been placed on a volunteer or student, the supervisor will alter their activities as needed.

2.11 The Director of Quality Improvement will collaborate with Directors to ensure that appropriate verbal and written communication is completed with employees and volunteers regarding actions taken to prevent reoccurrence.

2.12 The Director of Quality Improvement will notify the Quality Council and Leadership team monthly of the types of events, root cause(s) and action plans.

3.0 Complaints

3.1 All clients and their family members/caregivers have the right to voice a complaint and make changes to their care or service.

3.2 Complaints will be documented and investigated as per an Adverse Event.

3.3 The supervisor will contact the complainant as soon as possible to acknowledge receipt of their concern and they will be informed that an investigation will take place.

3.4 The supervisor will investigate the complaint using root cause analysis within the context of the PDSA framework as follows: Code 3 within 1 business day; Code 2 within 3 business days; Code 1 within 5 business days. A preliminary action plan will be developed for the employee or volunteer.

3.5 The initial disclosure of the Code 3 or Code 2 events will be made by telephone by the Supervisor and employee, student or volunteer, if appropriate, with the client and/or caregiver. A face-to-face meeting will be arranged at the request of the client or caregiver. A Code 1 event disclosure will be done at the discretion of the Supervisor and or Director/Manager. There may be situations where the initial disclosure will occur face-to-face at the time of the event. (Refer to Disclosure of Sentinel and Adverse Events policy).
3.6 Further disclosure can be made with the client and/or caregiver once the investigation has been completed.

3.7 The Supervisor is responsible for updating the Client Sentinel Adverse Event report once the investigation and disclosure is completed.

3.8 The Supervisor and Director/Manager will arrange a face-to-face meeting with the employee, student or volunteer as per the timelines in the action plan to provide support and ensure that all action plan items have been addressed, where applicable.

3.9 The Supervisor will communicate the action plan to other employees if applicable.

3.10 The Director of Quality Improvement will notify the Quality Council and Leadership team monthly of the types of complaints, root cause(s) and action plans. The Director of Quality Improvement will present a summary of all complaints received to the Board Quality Committee on a quarterly basis.

3.11 A complainant, witness, family member, caregiver or individual providing information, will not be penalized in any way for making a complaint or being involved in an investigation.

4.0 **Near-miss Event**

4.1 Employee/student Reporting: The employee will verbally report the event to their direct supervisor or on-call supervisor **within 4 hours** from the time of the event.

4.2 Volunteer Reporting:
- During Business Hours: The volunteer will verbally report the event to their coordinator **within 1 business day** of the event. If the coordinator cannot be reached, the call will be taken by another coordinator in the office.
- After Business Hours: The volunteer will call the Answering Service within 1 business day of the event. The Answering Service will page the on-call supervisor. The on-call supervisor will contact the Director of Community Support Services or designate.
- An Alzheimer Services Support and Education volunteer will contact the Education Coordinator by cell phone.

4.3 The Supervisor will collect the information on the Near-miss Event Report.

4.4 Disclosure of a near-miss event is not necessary however it is at the discretion of the Supervisor depending on the potential significance of impact on the client.
4.5 The Supervisor will communicate the action plan to the team if applicable.

5.0 **CCAC Significant Events Reports**

5.1 The Supervisor will investigate the event using root cause analysis within the context of the PDSA framework as follows: **Code 3 within 1 business day; Code 2 and Code 1 within 3 business days.** A preliminary action plan will be developed for the employee.

5.2 The Supervisor will complete the Significant Event Report once the investigation has been completed and forward it to the appropriate CCAC. A Sentinel, Adverse Event Report will be completed as necessary.

5.3 Disclosure of the event may be required if appropriate.

5.4 The Supervisor and Director/Manager will arrange a face-to-face meeting with the employee as per the timelines in the action plan to provide support and ensure that all action plan items have been addressed.

5.5 If restrictions have been placed on a Health Services employee, the Health Services Supervisor will notify the Client Service Coordinator. If restrictions have been placed on other employees the supervisor will manage their schedule.

5.6 The Director of Quality Improvement will collaborate with Directors to ensure that appropriate verbal and written communication is completed with employees regarding actions taken to prevent reoccurrence.

5.7 The Director of Quality Improvement will notify the Quality Council and Leadership team monthly of the types of events, root cause(s) and action plans.

6.0 **Other Events - Occurrence Reports**

6.1 Employee/Student Reporting: The employee/student will verbally report the occurrence event to their direct supervisor or on-call supervisor **within 4 hours** from the time of the event.

6.2 Volunteers will report the event within one business day.

6.3 These events that may or may not be related to a client will be documented on an Occurrence Report.
6.4 The supervisor will investigate the event using root cause analysis within **5 business days**. A preliminary action plan will be developed for the client, employee/volunteer, where applicable and communicated to the team where applicable.

**7.0 Outcome Measurement**

7.1 The Director of Quality Improvement will provide monthly quality reports to the Leadership Team and the Quality Council, and quarterly to the Board of Directors.

7.2 The Director of Quality Improvement and the Quality Council will develop recommendations to reduce Client Events, Near Misses and Occurrences.

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**Adopted:** July 2005  
**Reviewed:** July 2011  
Whistle Blower policy  
Accreditation Canada - Examples of Types of Sentinel Events (Appendix A)

<table>
<thead>
<tr>
<th>Approved by</th>
<th>Signature</th>
<th>Date</th>
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<tr>
<td>Chief Executive Officer</td>
<td>![Signature]</td>
<td>March 5, 2015</td>
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## Appendix A
### Accreditation Canada - Examples of Types of Sentinel Events (edited)

<table>
<thead>
<tr>
<th>Event Category</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Device or Product Events</strong></td>
<td>• Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the organization</td>
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<td>• Patient death or serious disability associated with the use or function of a device in a manner than the device’s intended use</td>
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<td>• Patient death or serious disability associated with intravascular air embolism</td>
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<td><strong>Patient Protection Events</strong></td>
<td>• Patient death or serious disability associated with elopement from the health care facility</td>
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<td>• Patient suicide, attempted suicide, or deliberate self-harm resulting in serious disability</td>
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<td>• Intentional injury to a patient by a staff member, another patient, visitor, or other</td>
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<td><strong>Environmental Events</strong></td>
<td>• Patient death or serious disability associated with an electric shock or electrical cardioversion</td>
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<td>• Patient death or serious disability associated with a burn incurred from any source</td>
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<td>• Patient death or serious disability associated with a fall</td>
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<td></td>
<td>• Patient death or serious disability associated with the use of restraints or bedrails</td>
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<td>• A line designated for oxygen or other gas came to be delivered to a patient and contains the wrong gas or is contaminated by toxic substances</td>
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<td>• Infection or disease that results in permanent disability or death</td>
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<td><strong>Case Management Events</strong></td>
<td>• Medication error leading to the death or serious disability of patient due to incorrect administration of drugs (e.g. omission, dosage error, dose preparation error, wrong time, wrong rate of administration, wrong administrative technique, wrong patient)</td>
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<td>• Patient death or serious disability associated with an avoidable delay in treatment or response to abnormal test results</td>
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<td><strong>Criminal Events</strong></td>
<td>• Any instance of care ordered by or provided by an individual impersonating a clinical member of staff</td>
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<td></td>
<td>• Abduction of a patient</td>
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<td>• Sexual assault on a patient within or on the grounds of the organization</td>
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<tr>
<td></td>
<td>• Death or significant injury to patient or staff member resulting from a physical assault or other crime that occurs within/on the grounds of org.</td>
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