GUELPH GENERAL HOSPITAL

HOSPITAL-WIDE MANUAL

Number: 17-101

POLICY & PROCEDURE: Reporting of Critical Incidents to Medical Advisory Committee, Board of Directors and President and Chief Executive Officer

Developed by: Senior Director, Patient Services Director of Quality and Professional Practice	**Review or Revision by:** Director of Quality and Professional Practice GGH Quality Council
Approval Date: Initial: June 23, 2010 Reviewed: May 2016, Jan 2021	**Review or Revision Date:** Every Three Years
Approved by: Marianne Walker, President and Chief Executive Officer	**Signature(s):** ____________________________

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See Policies:
1. GGH Policy #17-030 Disclosure of Harmful Incidents to Patients and Families
2. GGH Policy #17-071 Managing Incidents and Risk

Guelph General Hospital is committed, in accordance with Sections 2 (4), 2 (5) and 2 (6) of Regulation 965 of the Public Hospitals Act, to ensuring disclosure of a critical incident is made as soon as is practicable after the incident occurs to the affected patient as well as to the President and Chief Executive Officer, the Medical Advisory Committee (MAC) and the Board of Directors. The disclosure will include:

a. The material facts of what occurred with respect to the critical incident;
b. Consequences for the patient of the critical incident, as they become known; and
c. The actions taken and recommended to be taken to address the consequences to the patient of the critical incident including any health care or treatment that is advisable.

Procedure Statement

A “critical incident” refers to any unintended event that occurs when a patient receives treatment in the hospital,

(a) that results in death, or serious disability, injury or harm to the patient*, and

(b) does not result primarily from the patient's underlying medical condition or from a known risk inherent in providing the treatment. (Reference: Section 1 (1) of Regulation 965 of the Public Hospitals Act).

*Examples of serious disability, injury or harm include surgery on wrong body part, patient death associated with failure or breakdown of device, patient suicide, and medication error leading to major permanent loss of function.

Risk

When a critical incident occurs, timely and coordinated communication of the event is essential to ensure the event is appropriately managed. The President and Chief Executive Officer is accountable to take action to mitigate risks associated with a critical incident and to ensure appropriate follow-up is completed to avoid or reduce the risk of further similar critical incidents.

Responsibilities/Accountabilities

1. Physicians/staff involved in critical incidents are responsible for reporting the event immediately to the Director of the Service or, if outside of business hours, the Director-on-Call via Switchboard via Switchboard paging system or telephone office extension;

2. The Director of the Service or Director-on-call who receives the notification of the potential critical incident is responsible for the following notifications.
    a. Chief of the Department or delegate;
    b. The Senior Director of the Service and
    c. The Director of Quality and Professional Practice or delegate.
    d. The Director of Quality and Professional Practice or delegate, will send a Pre-Notification to the members of the Senior Management Team informing them of the potential critical incident and the next steps being undertaken.

3. The Director of Quality and Professional Practice working collaboratively with the Director of the Service and the Senior Director of the Service, will assess the current facts of the critical incident or potential critical incident and set up an urgent meeting with key individuals involved to assess the situation.

4. Based on the assessment of the situation, in collaboration with The Chief of Staff, Chief Nursing Executive and Director of Quality and Professional Practice, if it is deemed that an event meets the definition of a critical incident (as defined above) the following steps are immediately put into place and documentation of the notification will be kept up to date using the Documentation of Critical Incident Notification form (Appendix A) by the Director of Quality and Professional Practice or delegate.

   A. In accordance with GGH By-law 1-12, Section 17.01 (a), the Chief of the Department or Chief of Staff may immediately and temporarily suspend privileges if the behaviour, performance or competence of a Professional Staff member exposes, or is reasonably likely to expose patient(s), staff or other persons to harm or injury either within or outside of the Hospital.

   B. The President and Chief Executive Officer and Chief of Staff will report the critical incident to the Medical Advisory Committee at its next meeting.

   C. The President and Chief Executive Officer, and Chief of Staff will decide if notification to the Board is appropriate for the next meeting of the Board of Directors, or if the event requires immediate reporting to the Chair of the Board.

Aggregated Critical Incident Data

The President and Chief Executive Officer must provide aggregated critical incident data to the Quality Committee at least two times a year. This would include data about all critical incidents occurring at the hospital since the previous report submitted. Where the Medical Advisory Committee identifies systemic or recurring quality of care issues, the Medical Advisory Committee must make recommendations about those issues directly to the Quality Committee. The Quality Committee will take these recommendations into consideration when making recommendations to the Board regarding quality improvement initiatives and polices. (Ontario Regulation 448/10 under the Public Hospitals Act (PHA) was filed on December 2, 2010. This regulation amended Regulation 965 under the PHA, effective January 1, 2011, to support the Excellent Care for All Act, 2010.)

Limits

This policy pertains to the management of critical incidents (as defined above) in relation to the notification process to the President and CEO, the Chief of Staff, the Medical Advisory Committee and the Board of Directors.

This policy was developed to complement existing GGH policies that describe "Disclosure of Harmful Incidents to Patients and Families" (17-030) and "Managing Incidents and Risk" (17-071).

References

Public Hospitals Act – R.S.O. 1990, Regulation 965

Ontario Hospitals Association Legislative Update – Amendments to Regulation 975 under the Public Hospitals Act Re: Critical Incident Reporting

Guelph General Hospital By-Law 1- 12

Keywords

Critical Event
Excellent Care for All Act
Disclosure to Medical Advisory Committee
Disclosure
CEO
Disclosure to MAC/ Board of Directors

Appendix A

Critical Incident Notification to Medical Advisory Committee and President and Chief Executive Officer

Reported by: ______________________ Date of report: ______________________

Patient G # ____

Staff Involved: ____

Brief Description: ____

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Disclosure to patient completed?

☐ NO

☐ YES By Whom: ______________ Date of Disclosure: ______________

Current Status of Patient:

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Next Steps:

- ☐ Critical Incident Reported to Chief/Dir/On-Call Date: ______________
- ☐ Report received by Sr. Director/Director (Quality) Date: ______________
- ☐ Report received by VP, Pt Services/CNE Date: ______________
- ☐ Report received by President & CEO Date: ______________
- ☐ Report received by Chief of Staff Date: ______________
- ☐ Briefing to Chief of Staff Date: ______________
- ☐ Briefing to CEO/VP Date: ______________
- ☐ Disclosure to MAC/MAC Executive Date: ______________
- ☐ Disclosure to Board/Executive Committee Date: ______________

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