



TITLE

RECOGNIZING, RESPONDING TO, AND LEARNING FROM HAZARDS, CLOSE CALLS, AND CLINICAL ADVERSE EVENTS

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NOTE: The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

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OBJECTIVES

- To provide **health care providers** with a standard approach to reporting and managing patient safety **hazards, close calls, and clinical adverse events (CAEs)**.
- To ensure that the needs of the **patient** and health care providers are managed appropriately.
 - In this Policy Suite, references to the patient will include the patient's **family**, if the patient wishes.
- To promote organizational learning and to support quality and patient safety improvement.

PRINCIPLES

Patients: Alberta Health Services (AHS) believes in a collaborative approach to improvement that includes engagement with patients and those who have been involved in CAEs. Health care providers should work to help support patients and to rebuild trust in AHS.

Our People: AHS recognizes that health care providers may also be harmed when a CAE occurs. When patients are harmed, health care providers may suffer from professional and personal anguish. Health care providers should be supported and treated with care, compassion, respect, and dignity.

Patient Safety: Health care providers aim to minimize risks to patients' physical and psychological well-being. Patients and health care providers should not be exposed to **harm**

where it is reasonably avoidable. Health care providers, to the extent they have control, and health systems are accountable for the quality of patient care they provide to patients.

Just Culture: AHS supports all those involved with empathy and thoughtfulness following a CAE. AHS strives to create an environment where everyone feels safe, encouraged, and enabled to discuss safety concerns. When a CAE occurs, actions are evaluated impartially in consideration of the circumstances and context of what occurred, rather than results and outcomes. Health care providers should avoid the temptation to reduce complex issues to simple individual human error.

Learning: AHS recognizes that understanding and learning from CAEs is essential to improving patient safety. This is accomplished respectfully with the utmost sensitivity, empathy, and compassion for all involved.

APPLICABILITY

Compliance with this document is required by all Alberta Health Services employees, members of the medical and midwifery staffs, students, volunteers, and other persons acting on behalf of Alberta Health Services (including contracted service providers as necessary).

ELEMENTS

1. Overview of the AHS Patient Safety Policy Suite

- 1.1 The AHS *Patient Safety* Policy Suite contains the following six (6) governance documents to guide health care providers to prevent and manage hazards, close calls, and CAEs.
 - a) *AHS Recognizing, Responding To, and Learning From Hazards, Close Calls, and Clinical Adverse Events* Policy;
 - b) *AHS Immediate and Ongoing Management of Clinical Adverse Events* Procedure;
 - c) *AHS Reporting of Clinical Adverse Events, Close Calls, and Hazards* Procedure;
 - d) *AHS Disclosure of Harm* Procedure;
 - e) *AHS Patient Safety Alerts, Safer Practice Notices, and Patient Safety Memos* Procedure; and
 - f) *AHS Patient Safety Learning Summary* Procedure.
- 1.2 AHS leaders become aware of patient safety hazards, close calls, and CAEs through a number of different ways, including but not limited to:
 - a) notification from health care providers;
 - b) the **Reporting and Learning System (RLS) for Patient Safety**;

- c) notification from Patient Relations; and
- d) the AHS *Urgent Notification to an Emerging Issue Report*.

2. Immediate and Ongoing Management of CAE

- 2.1 When a health care provider recognizes a possible CAE has occurred, they shall report it to a **clinical leader**.
- 2.2 Immediate management of a CAE shall be coordinated by a single clinical leader ideally within 24 hours of the CAE being identified to ensure a fair and consistent response in accordance with the AHS *Immediate and Ongoing Management of Clinical Adverse Events Procedure*.
 - a) Some CAEs may be concluded after the immediate management, if there is no need for ongoing management.
- 2.3 If further follow-up is required for the CAE, the clinical leader shall hand over the management of the CAE to an **accountable leader**. The accountable leader shall use a fair and consistent process in accordance with the AHS *Immediate and Ongoing Management of Clinical Adverse Events Procedure*.
- 2.4 Ongoing management of a CAE starts when the clinical leader completes handover to the accountable leader, ideally within 48 hours of the CAE being identified.
- 2.5 In order for patient safety to improve, the accountable leader shall take reasonable steps and collaborate with the health care team to share what was learned from the review of a CAE with relevant stakeholders within AHS and ensure that effective actions are taken to improve quality and safety.

3. Reporting of CAEs, Close Calls and Hazards

- 3.1 AHS is committed to fostering a **just culture** environment where everyone feels safe, encouraged, and enabled to report quality and safety concerns (refer to Appendix A: *AHS Just Culture Guiding Principles* and *Just Culture* guiding resources on Insite).
- 3.2 The RLS is the province-wide system for health care providers to report CAEs, close calls, and hazards related to patient safety for the purpose of learning and improving patient safety in the health care system. Refer to the AHS *Reporting of Clinical Adverse Events, Close Calls, and Hazards Procedure*.
- 3.3 The RLS allows AHS leaders to review CAEs, close calls, and hazards individually and in aggregate in order to support patient safety.
- 3.4 Reporting to RLS does not replace health care providers requirements to:
 - a) notify clinical leaders of CAEs (refer to Section 2); and

- b) document the known facts about the event in the patient's health record.
- 3.5 Leaders, Managers, and **RLS users** receiving RLS reports have a responsibility to respond to identified hazards, close calls, and CAE(s) reported through RLS in accordance with the AHS *Immediate and Ongoing Management of Clinical Adverse Events* Procedure.
- 4. Disclosure of Harm**
- 4.1 AHS requires **disclosure of harm** conversations to be conducted with patients if there has been any harm, if there is any risk of potential future harm, or if there is any change in patient care or monitoring as a result of the CAE, in accordance with the AHS *Disclosure of Harm* Procedure.
- 5. Share Lessons Learned and Improve**
- 5.1 AHS leaders have a responsibility to share lessons learned from CAE(s) with health care providers.
- 5.2 Health care providers have a responsibility to support improvement initiatives and mitigate risk to improve patient safety.
- 5.3 When there is an opportunity to learn broadly from a CAE, there shall be consideration for completion and distribution of a **Patient Safety Learning Summary (PSLS)**. A **Patient Safety representative** may assist in accordance with the AHS *Patient Safety Learning Summary* Procedure.
- 5.4 As appropriate, when a patient safety hazard (a set of circumstances that if left unchanged could harm or contribute to the harm of a patient) is identified, a **Patient Safety Alert (PSA)**, **Safer Practice Notice (SPN)**, or **Patient Safety Memo (PSM)** are methods available to inform. A Patient Safety representative may assist in accordance with the AHS *Patient Safety Alerts, Safer Practice Notices, and Patient Safety Memos* Procedure.

DEFINITIONS

Accountable leader means the individual who has ultimate accountability to ensure the consideration and completion of the listed steps in the management of the AHS *Recognizing, Responding To, and Learning From Hazards, Close Calls, and Clinical Adverse Events* Policy and procedures. Responsibility for some or all of the components of management may be delegated to the appropriate level responsible administrative leader, but the accountability remains at the senior level.

Alternate decision-maker means a person who is authorized to make decisions with or on behalf of the patient. These may include, specific decision-maker, a minor's legal representative, a guardian, a 'nearest relative' in accordance with the *Mental Health Act* (Alberta), or an agent in accordance with a Personal Directive, or a person designated in accordance with the *Human Tissue and Organ Donation Act* (Alberta). This also includes what was previously known as the substitute decision-maker.

Clinical adverse event (CAE) means an event that reasonably could or does result in an unintended injury or complications arising from health care management, with outcomes that may range from (but are not limited to) death or disability to dissatisfaction with health care management or require a change in patient care.

Clinical leader means the senior leader immediately available to provide immediate management of a clinical adverse event. This may be a charge nurse, on-duty supervisor, administrator on call, most responsible health practitioner, Unit Manager, or other leader as appropriate.

Close call means an event that has potential for harm and is intercepted or corrected prior to reaching the patient.

Co-decision-maker means a person selected by the patient and appointed by the Court to make decisions in partnership with the patient, when the patient has significantly impaired capacity but can still participate in decision-making.

Disclosure of harm means the formal process involving an open discussion between a patient and staff of Alberta Health Services about the events leading to a serious clinical adverse event, hazard, or harm.

Family(-ies) means one or more individuals identified by the patient as an important support, and who the patient wishes to be included in any encounters with the health care system, including but not limited to, family members, legal guardians, friends, and informal caregivers.

Harm means an unexpected outcome for the patient, resulting from the care and/or services provided, that negatively affects the patient's health and/or quality of life.

Hazard means something that has the potential to contribute to harm.

Health care provider means any person who provides goods or services to a patient, inclusive of health care professionals, staff, students, volunteers and other persons acting on behalf of or in conjunction with Alberta Health Services.

Just culture means an environment where everyone feels safe, encouraged, and enabled to discuss quality and safety issues, where reporting and learning are key elements.

Most responsible health practitioner means the health practitioner who has responsibility and accountability for the specific treatment/procedure(s) provided to a patient and who is authorized by AHS to perform the duties required to fulfill the delivery of such a treatment/procedure(s) within the scope of their practice.

Patient means all persons, inclusive of residents and clients, who receive or have requested health care or services from Alberta Health Services and its health care providers. Patient also means, where applicable:

a) a **co-decision-maker** with the person; or

b) an **alternate decision-maker** on behalf of the person.

Patient Safety Alert (PSA) means the notification used by clinical leaders to bring attention to a significant patient safety hazard and requires health care providers to take immediate action. The risk is usually applicable across multiple zones.

Patient Safety Learning Summary (PSLS) means the standard document and collaborative process to ensure that patients, families, and health care providers can see the linkage between reporting, managing, and analyzing clinical adverse events and other types of initiatives, culminating in the sharing of transparent, respectful, and non-identifying recommendations for improvement and organizational learning.

Patient Safety Memo (PSM) means the notification used by clinical leaders to bring attention to a patient safety hazard and advise health care providers to take recommended action. The risk is usually limited to a targeted audience within a unit, site, or program within a single zone.

Patient Safety representative means the staff employed to promote quality patient care and patient safety at a site, program, business area, Zone, or provincial level.

Reporting and Learning System (RLS) for Patient Safety means the electronic software program designated by Alberta Health Services to report patient related events resulting in adverse events, close calls, or hazards.

RLS users means the Managers, leaders, and designates that AHS have been granted access to receive email notification, review, and use RLS reports. RLS users are assigned to exact locations.

Safer Practice Notice (SPN) means the notification used by clinical leaders to bring attention to a patient safety hazard and informs health care providers to take action based on recommended patient care practices. The risk is usually applicable across multiple zones.

REFERENCES

- Appendix A: *AHS Just Culture Principles Guiding Principles*
- Alberta Health Services Governance Documents:
 - *Collection, Access, Use, and Disclosure of Information Policy* (#1112)
 - *Disclosure of Harm Procedure* (#PS-95-01)
 - *Immediate and Ongoing Management of Clinical Adverse Events Procedure* (#PS-95-02)
 - *Medical Device Incident or Problem Reporting Procedure* (#PS-103-03)
 - *Patient Safety Alerts, Safer Practice Notices, and Patient Safety Memos Procedure* (#PS-95-05)
 - *Patient Safety Learning Summary Procedure* (#PS-95-06)
 - *Reporting of Clinical Adverse Events, Close Calls, and Hazards Procedure* (#PS-95-04)
- Alberta Health Services Resources:
 - Just Culture Resources
 - *Urgent Notification to an Emerging Issue Report*

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- Non-Alberta Health Services Documents:
 - *Alberta Evidence Act (Alberta)*

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APPENDIX A

AHS Just Culture Guiding Principles

AHS has seven (7) guiding principles supported by an organizational commitment to help us live a just culture.

When there is a need to review a situation, whether in a clinical or non-clinical area:

1. Alberta Health Services (AHS) will ensure a fair and consistent approach to evaluating what occurred in context and responding to the individuals involved.
2. Everyone will be able to trust that AHS has effective processes in place to support this fair and consistent approach, and that these processes will be followed.
3. Actions will be evaluated in consideration of the circumstances and context of what occurred, rather than results and outcomes.
4. Individuals will not be held accountable for system and/or organizational errors over which they have no control and will be treated with care, compassion, support, respect and dignity.
5. AHS Leaders are accountable for ensuring system and/or organizational changes/ improvements are made based on what we learn and the leading evidence. Throughout that process, they will engage with those who work within/are impacted by the system and/or organization (including patients, families, staff and medical staff).
6. Individuals will feel enabled, empowered and supported to openly discuss and report what occurred.
7. Individuals will be held appropriately accountable for reckless behavior or intent to harm.