NOVA SCOTIA
Seniors and Long-Term Care

CRITICAL INCIDENT REPORTING POLICY

Originating Division: Continuing Care

Approved By: Tracey Barbrick
Tracey Barbrick, Deputy Minister
Seniors and Long-Term Care

Original Approval Date: June 5, 2009

Version: 2

Revised Date: February 8, 2024

1. INTRODUCTION

1.1. The Nova Scotia health system continuously strives to maintain and improve on the safety of healthcare practices and the environment in which health care and services are provided. This can, in part, be achieved through the review and analysis of actual or potential incidents which pose risks to an organization, its personnel and suppliers, and the people receiving its services. When shared across the health system, lessons learned from such reviews can facilitate process improvement and hazard prevention.

The Nova Scotia Department of Seniors and Long-Term Care plays a coordinating role in ensuring that relevant safety information is collected and disseminated across the health system in a systematic fashion. In maintaining and improving the quality of the health care system, Continuing Care Service Providers and the Department of Seniors and Long-Term Care ("The Department") have individual responsibilities.

Continuing Care Service Providers have a responsibility to:

- investigate and act on Critical Incidents;
- report Critical Incidents to The Department; and
- work with The Department and other agencies in delivering public communication about incidents or events when confidence in the healthcare system is at issue.

1.2. The Department has the responsibility to:

- assess Critical Incidents for broad system practice and policy implications;
- issue associated system alerts;
- address policy changes;

- work with Continuing Care Service Providers in delivering public communication about incidents or events when confidence in the healthcare system is at issue.

2. POLICY STATEMENT

2.1. Continuing Care Service Providers are required to report Critical Incidents to The Department. Service Providers are defined in Section 3 of this policy.

3. DEFINITIONS

Adverse Event: An unexpected and undesired incident directly associated with the care or services provided to the client or the environment in which the care is provided, resulting in harm and/or death.

Authorized Decision Maker: Anyone who has legal authority to make decisions on behalf of an individual. This is often referred to as legal representative or substitute decision-maker and includes, but is not limited to, persons who have authority under the Hospital Act, Medical Consent Act, the Power of Attorney Act, under a guardianship order, other relevant legislation or applicable health care agency policy (such as consent policy).

Client: An individual who receives care or service from service providers referred to in this policy; this includes those referred to as patients or residents and their families, where appropriate, and authorized decision-makers for the client.

Critical Incident: A Critical Incident is a serious event, effecting either the client staff of service providers or the public including, but not limited to:

a. The actual or potential loss of life, limb, or function related to a health service provided by, or a program operated by, a service provider;
b. An event that has or may have a negative impact on service operations;
c. An event that poses a threat to public health;
d. An event that may have a negative impact on the public trust in the healthcare system.

Disclosure: The imparting, by health care-workers to clients of information pertaining to any adverse event affecting (or liable to affect) the client's interests.

Harm: An outcome that negatively affects the client's health and/or quality of life.

Continuing Care Service Providers: The Nursing Homes and Homes for the Aged, Residential Care Facilities (RCF), Community Based Options (CBO), Home Care Agencies and Home Oxygen Providers which are funded, licensed or approved by The Department.

Incidents: Events, processes, practices, or outcomes that are noteworthy by virtue of the hazards they create, or the harms they cause.

Near Miss: A near miss is an event or circumstance which "almost happened" but may not have reached the client due to chance, corrective action, and/or timely intervention.

Sentinel Event: A sentinel event is an adverse event which leads to death or major and enduring loss of function for a recipient of healthcare services. Major and enduring loss of

function refers to sensory, motor, physiological or psychological impairment not present at the time services were sought or began. The impairment lasts for a minimum period of two weeks and is not related to an underlying condition.

4. POLICY OBJECTIVES

4.1. The objectives of this policy are to:

4.1.1 provide a consistent process for Continuing Care Service Providers to notify The Department of Critical Incidents; and

4.2.1 provide timely information that will facilitate policy and process improvement across the health system

5. POLICY APPLICATION

5.1. This policy applies to all Continuing Care Service Providers, receiving public funds to deliver health care services.

6. POLICY DIRECTIVES

6.1. Continuing Care Service Providers manage Critical Incidents according to their own administrative and quality management policies.

6.2. Continuing Care Service Providers shall notify The Department about Critical Incidents which may include, but are not limited to:

6.2.1. preventable death or serious health impairment to a client, visitor or health care personnel directly associated with care and services provided by a health care agency;

6.2.2. unanticipated disruption to healthcare services greater than twenty-four hours duration;

6.2.3. privacy breach;

6.2.4. events which involve multiple clients and/or require retroactive notification of groups of clients about an event or exposure risk

6.2.5. criminal activity (such as abduction, sexual assault, major theft or embezzlement);

6.2.6. conditions perceived as public health hazards or disaster management events;

6.2.7. events which have the potential to undermine public confidence in the health care system;

6.2.8. if none of the above applies, Continuing Care Service Providers should use their judgment in reporting actual or potential critical incidents that may represent hazards across the health system.

6.3. The Department and Continuing Care Service Providers shall participate in collaborative communication planning when informing the public about major Critical Incidents.

6.4. Continuing Care Service Providers shall participate in inter-organization action and/or provincial review of practices or policies when appropriate.

7. PROCEDURE

7.1. Continuing Care Service Providers shall report Critical Incidents to The Department by the end of the next Business Day.

7.1.1. A senior administrator, or delegate, designated by the Continuing Care Service Provider, shall contact The Department during regular working hours to provide SLTC with the required information.

7.1.2. In cases of public health hazards, a Continuing Care service provider is required to notify the provincial Medical Officer of Health (MOH) through the established procedures, as set out by the MOH.

7.1.3. Continuing Care Service Providers shall continue to report disaster management events through relevant emergency response systems.

7.2. Continuing Care Service Providers must submit Critical Incidents using the online forms. Continuing Care Service Providers shall provide no reference to personal names or other characteristics in which the Critical Incident would serve to identify an individual.

7.2.1. Critical Incident Report Form Link
https://forms-beta.novascotia.ca/NewSubmission/3ec46fb2-cd64-4266-840e-a8a0ffa35214

Critical Incident Follow Up Form Link

https://forms-beta.novascotia.ca/NewSubmission/15fb0019-0d07-41e9-9cdd-811c5e00f47a

7.2.2. Service providers must communicate factual details of the Critical Incident and its outcome.

7.2.3. The following information shall be provided on submission:

a. Nature of the incident
b. Location of the incident
c. Time and date of occurrence
d. Description of the incident
e. Impact of the incident and applicable corrective actions taken

7.3. The Continuing Care Service Provider shall provide a follow-up plan and an updated status report to the Department within 30 working days. The following information shall be provided:

a. Action taken to address immediate safety of clients and staff

b. Action to prevent the incident from happening again
c. Target dates for future action if action has not been completed

8. ACCOUNTABILITY

8.1. The Senior Executive Director, SLTC, is responsible for ensuring compliance with this policy.

9. MONITORING/OUTCOME MEASUREMENT

9.1. The implementation, performance, and effectiveness of this policy will be monitored by the Senior Executive Director, SLTC.

10. REFERENCES

10.1. This policy is aligned with both the Department of Seniors and Long-Term Care, and the Department of Health Disclosure of Adverse Events Policy.

11. INQUIRIES

All inquiries relating to this policy should be directed to:

ContinuingCare@novascotia.ca
Nova Scotia Department of Seniors and Long-Term Care
PO Box 2065
Halifax, NS B3J 3X8

VERSION CONTROL

Version 2	**Effective: February 8, 2024** Administrative amendments to remove fax/telephone requirement, add online form submission and update Department. Replaces all previous versions.