Reporting of Critical Incidents Related to Medication/IV fluids

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Ontario

Today

- Patient Safety Reporting in Ontario
- Excellent Care for All Act (ECFAA) and Patient Safety
- ECFAA and Critical Incident Reporting
- The National System for Incident Reporting (NSIR)
- Provide an overview of Mandatory Reporting on Critical Incidents Related to Medication / IV Fluid

Patient Safety: Results Through Reporting

- 100% compliance in reporting safety related indicators since launch in 2008.
- Public reporting has resulted in greater focus on safety, and improvements in practice:
  - CDI rates have shown a decline since public reporting began. The overall provincial rate for the first twelve months of reporting (Aug 2008 – Jul 2009) was 0.35 cases per 1,000 patient days compared to 0.32 cases per 1,000 patient days for the most recent twelve months (Jul 2010 – Jun 2011).
  - A 2006 study showed hand hygiene compliance in selected Ontario hospitals was 32%. In April 2011, Ontario hospitals reported a compliance rate of 73% before patient contact and 83% after patient contact.
- Tone of media coverage changed significantly as a result of public reporting.
- The provincial compliance rate to the WHO recommended Surgical Safety Checklist was 99% as of January 2011.

All of Ontario's patient safety indicators compare favourably to other jurisdictions.

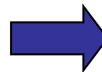
ECFAA and Patient Safety

- The *Excellent Care for All Act, 2010* legislative requirements include:
  - **Quality** committees, which will report to health care organizations on **quality-related** issues
  - Annual **quality** improvement plans, which each health care organization will be required to develop and make public
  - Executive compensation which will be required to be linked to achieving improvement targets set out in the annual **quality** improvement plan
- **Safety, as a dimension of quality, focuses on the prevention of patient safety incidents (or adverse events)**

ECFAA and Critical Incident Reporting

- The *Excellent Care for All Act, 2010* legislates that hospital annual quality improvement plans must be developed having regard to its aggregated critical incident data as compiled based on disclosures of critical incidents pursuant to regulations made under the *Public Hospitals Act* (PHA).
- Following disclosure of a critical incident, hospital boards are now required to ensure that the hospital administrator establishes a system for analyzing the critical incident and developing a system-wide plan to avoid or reduce the risk of further similar incidents. In addition, as of January 1, 2011, the PHA Regulation 965 was amended to ensure that the administrator provides aggregated critical incident data to the quality committee at least two times per year.
- **However, there is no requirement to report critical incident data beyond the hospital**

Critical incident is defined by Regulation 965 under the PHA (R.S.O. 1990, c. P.40) to mean any unintended event that occurs when a patient receives treatment in the hospital that results in death, or serious disability, injury or harm to the patient, and does not result primarily from the patient's underlying medical condition or from a known risk inherent in providing the treatment.



Beginning July 1, 2010, existing requirements for hospitals to disclose critical incidents to patients were expanded to include disclosure to the Medical Advisory Committee (MAC) & hospital administrator. The hospital boards are also required to ensure that a system is established to analyze each critical incident and that a plan is developed with systemic steps to avoid or reduce the risk of further similar critical incidents.

Effective January 1, 2011, further amendments to Regulation 965 under the PHA require aggregate critical incident reporting to the quality committee at least two times per year.

Patient Safety Incident Reporting Systems in Other Jurisdictions: Ontario is entering the game

	Prior to 2010/11	FY 2010/11	FY 2011/12
Ontario Ministry of Health and Long-Term Care	*(Public reporting of Patient Safety Indicators began Sept 2008)*	*ECFAA*	**Mandatory reporting of critical incidents related to medications/IV fluids**
Newfoundland Dept of Health and Community Services			Provincial adverse event reporting system
Quebec's Ministère de la Santé et des Services sociaux (MSSS)		Provincial registry for adverse events	
Alberta Health Services (AHS)		AHS Provincial Reporting and Learning System (RLS) implemented March 2011	
British Columbia's Patient Safety & Quality Council	BC Patient Safety & Learning System (BC PSLS) launched 2008; province-wide submission to NSIR later in FY 2011/12		
Manitoba (Brandon Regional Health Authority)	A regional database of incidents is maintained for tracking purposes[1]		
Northwest Territories	Hay River Health & Social Service Authority (HRHSSA) Incident/Near Miss Reporting System established[1]		
Saskatchewan (Saskatoon Regional Health Authority)	Participated in NSIR pilot (2008) and continue to report to NSIR (officially launched April 2010)		
UK's NHS National Patient Safety Agency	The National Reporting and Learning System (NRLS), established 2003		
United States (22 States)	Mandatory adverse event reporting systems in place[2]		

[1] CPSI (Baker R. et al). Appendix B: Review of Provincial, Territorial and Federal Legislation and Policy Related to the Reporting and Review of Adverse Events in Healthcare in Canada. Nov 2007. [2] Bleich S. Medical errors: Five years after the IOM report. Issue Brief (Commonwealth Fund). 2005 July; (830):1-15.

The Way Forward in Ontario: NSIR

- In an OHA survey of its members, 98% of organizations reported that they currently have a critical incident reporting system in place
- Building on this excellent work to date in Ontario hospitals, we will continue to push the quality agenda in order to ensure resources and investments directed towards safety are providing value to the system and are effectively preventing adverse events that are high risk and high cost to the patient and the health system
- Standard patient safety incident reporting is critical to providing health care providers with the information required for making improvements to the safety of health care

Why NSIR?

- The Canadian Institute for Health Information (CIHI) has developed a web-based application called NSIR
- **NSIR is a system that can be used by all hospitals regardless of the level of implementation of their existing incident reporting systems**
- **NSIR is a tool that allows users to securely and anonymously report, analyze, discuss and share information on patient safety incidents**
- **NSIR's standardized data and analyses inform quality improvement activities and is based on the World Health Organization's International Classification for Patient Safety**
- Currently, the NSIR system only collects data on medication / IV fluid incidents that occur during medication management, including rare event and near-miss incidents
- In time, NSIR will be expanded to include other types of patient safety incidents

NSIR Mandatory Data Elements (11)

- Degree of harm
- Functional area(s)
- Date incident was detected
- Time (or time period) incident was detected
- Month and year of birth
- Patient sex
- Medication/IV fluid use process
- Medication/IV fluid problem
- Contributing factor(s)
- Type of drug product (ex. Marketed, Special Access, etc)
- Name of drug (DIN, generic or brand name; taken from NSIR Drug Product Database)

NSIR Optional Data Elements (18)

- Description of the medication incident (recommended)
- Ward/Unit within hospital
- Date incident occurred
- Time (or time period) incident occurred
- Health care provider(s) who detected incident
- Health care provider(s) who were involved in incident
- Repeated administrations
- Dosage form
- Strength
- Route of administration
- Batch number/lot number
- Patient informed of incident
- Likelihood of recurrence
- Intervention(s) required
- Extended length of stay
- Unplanned admission/readmission to hospital
- Root cause analysis status
- Future strategies/recommendations

Mandatory Reporting Requirements, Cont'd

- CIHI is working with vendors to implement 'batch' upload which will allow hospitals to submit data directly to NSIR from their incident reporting systems

- Until batch upload is available, hospitals will be required to enter critical incidents related to medication/IV fluids to both their internal incident reporting systems and to NSIR

- Critical incidents related to medication/IV fluids are a small fraction of incidents and should not place an undue burden on the field

Summary

- ECFAA requires quality improvement and implementation plans to improve patient safety (QIP), including internal reporting of all types of critical incidents
- Continuous improvement processes require implementation of best-practices which are built from standard reporting and information sharing
- NSIR provides hospitals with a standard system to share information and learn from critical incidents related to medication/IV fluids, province-wide
- This initiative builds on the continued innovative work of Ontario hospitals to improve patient safety and quality of care