

## RL6 Safety Reporting

#### Information about:

- 1. Definitions of types of Safety Events
- 2. Reasons for RL Safety Reporting
- 3. Use of RL Safety Event Reporting submission form
- 4. Where to find additional information

The reporting system has changed to improve the efficiency and effectiveness of the process. There are many 'delays' in the current process when the form is sitting on a managers/directors/quality desk. A key goal is to reduce delays to help improve the quality and safety of care.

The system will also make it easier to extract the information to plan system improvements.

This training will help you understand the purpose and of and process for using RL6 Risk.



### **Near Miss - Defined**

An event which did not reach the patient. It's a "good catch" It's an opportunity to support the development of processes and structures that prevent a similar event from ever reaching the patient



Reporting in RL6 Risk strongly supported and encouraged

#### **Public Health Examples**

- Wrong dose, or wrong medication or vaccine, but noticed just before administration.
- Someone leaning over the counter to read what is on your screen but you quickly change your screen before they can read personal health information.
- Someone uses and outdated disease management protocol without checking the website first. No harm was done to the patient.
- Condoms or epinephrine kits are left in the van by a previous staff person while the sun is beating on it and no air conditioning is on. The previous staff person told you they have packed the van. You are about to drive off when you feel the boxes and they are hot.
- Potential cold chain failure due to incorrect packaging.
- Constantly 'wavey' carpets in the entrance to our service area that pose a tripping hazard.



## Occurrence - Defined

A <u>patient-related</u> event or circumstance that resulted in an unintended and undesired outcome such as an injury to a patient and/or damage to or loss of equipment or property

It's an opportunity to support the development of processes and structures that prevent a similar event from reaching the patient.

#### Reporting in RL6 Risk required

- Wrong dose, or wrong medication or vaccine, and it was administered.
- Someone leaning over the counter to read what is on your screen and they read personal health information.
- Someone uses and outdated disease management protocol without checking the website first. The patient is given less than optimal care.
- Condoms or epinephrine kits are left in the van by a previous staff person while the sun is beating on it and no air conditioning is on. The previous staff person told you they have packed the van. Clients tell you that these condoms broke.
- Vaccine failure due to breaks in cold chain.
- A client falls due to 'wavey' carpets in the entrance.



### **Critical Incident - Definition**

An unintended event that occurs when health services are provided to an individual and results in a consequence to him or her that:

- is serious and undesired, such as death, disability, injury or harm, unplanned admission to hospital, or unusual extension of a hospital stay, and;
- does not result from the individual's underlying health condition or from a risk inherent in providing the health services.

Staff must report, but can chose to report in RL6 Risk or by calling the WRHA Critical Incident Reporting and Support Line (CIRSL), 24 hours a day, 7 days a week at 204-788-8222. Callers may report anonymously.

- Someone falls out of the Street Connections van and breaks their wrists resulting in hospitalization.
- Our epinephrine kits are outdated and someone dies.
- A nurse fails to do an assessment of a wound despite the client's complaints and the client eventually ends up in an emergency department to deal with this.
- Client is given wrong vaccine and is taken by ambulance to emergency due to an anaphylactic reaction.



## **Critical Occurrence - Defined**

Is an event that <u>does not directly involve patients</u>, but involves one or more of the following:

- serious harm to employees, medical staff, volunteers, students, visitors, and other persons associated with the facility or service
- the potential to negatively affect public confidence, credibility and trust, including potential media involvement or litigation
- unplanned or unexpected disruptions to the delivery of services and programs
- an emergency or disaster
- a significant public health event

Typically you don't need to be involved in this reporting. Bring this to the attention of your Team Manager.



# What happens after I report?

#### Managers and Directors are

- Required to review the event in RL and complete any follow-up required and document actions taken.
- Upon request, provide feedback to the individual who reported the event in collaboration with others involved in the event, as appropriate.



## Getting into RL6 Risk



**Double-click** on the **RL** 

Desktop. You do not need to login

Icon on the

https://rl6.rlsolutions.com/WRHA Prod/Homecenter/Client/Home.aspx

### When I am stuck?

You can find links to helpful documents by going to:

- Insite
- Programs
- Population and Public Health
- Standards, Policies, Procedures & Guidelines

http://www.wrha.mb.ca/extranet/publichealth/standards.php