APPENDIX A

Manitoba Critical Incident Reporting Guidelines

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

(a) is serious and undesired, such as death, disability, injury or harm, unplanned admission to hospital or unusual extension of a hospital stay, and

(b) does not result from the individual's underlying health condition or from a risk inherent in providing the health services.

The following reporting guidelines provide examples of events that are reportable to the Minister of Health as critical incidents. These guidelines do not replace the above definition, nor are they intended to be inclusive of only those events which meet the definition of a Critical Incident. Examples of critical incidents may include the following:

Falls:

- Falls associated with serious injury and/or fractures; if you can answer “YES” to one or more of the following questions
    - Was this reasonably believed to be preventable considering the patient’s underlying condition(s), the care plan, circumstances and context, and clinical judgment?
    - Was there equipment failure/breakdown/misuse that could have contributed to the fall?
    - Was the use or misuse of restraints a contributing factor to the fall?
    - Was there a breach of policy that could have contributed to the fall?
    - Were there environmental factors involved that contributed to the fall?

Clinical Care:

- Patient death or serious disability associated with a fluid administration error
- Patient death associated with a hemolytic reaction due to the administration of ABO incompatible blood or blood products
- Patient death associated with severe hypoglycemia, the onset of which occurs while in the care of the organization/facility
- Error in diagnosis, where the treatment provided or not provided, is associated with patient death or serious disability
- Patient death or serious injury associated with a delay or failure to transfer a critically ill patient to more appropriate care delivery facilities
- Stage 3 or 4 pressure ulcers acquired after admission to a health care facility
- Full term fetal or neonatal death or serious disability associated with labor and delivery while being cared for by the RHA
- Maternal death or serious disability while being cared for in the RHA
- Death of a patient associated with a hospital acquired infection

Medications:
- Patient death or serious disability associated with medication error, including: the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation or the wrong route of administration

Surgical:
- Surgeries performed on a wrong body part
- Surgeries performed on the wrong patient
- The wrong surgical procedure performed on a patient
- Retention of a foreign body in a patient after surgery or procedure
- Death during or immediately following surgery in a patient with a low anaesthetic risk score
- Unintentional awareness during surgery with recall by the patient
- An adverse health event leading to death or serious disability associated with surgery

Patient Protection:
- An infant discharged to the wrong person(s)
- Patient death or serious disability associated with patient disappearance
- Patient suicide or attempted suicide, while under care of an organization/facility, including events that result from patient actions after admission to a facility or program of the RHA or health care organization.
- An adverse health event leading to death or serious disability associated with the delivery of a health care service

Environment:
- Patient death or serious disability associated with electric shock, burns, the use of restraints
- Patient death or serious disability associated with the failure or de-activation of exit alarms or environmental monitoring devices
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances

Equipment/Devices:
- Patient death or serious injury associated with use of contaminated drugs, devices and biologics or the use/function of a device in patient care when the device functions other than intended

Emergency Medical Services:
- Patient death or serious injury associated with transport arranged or provided by the facility/organization
- Patient death or serious injury associated with a delay or failure to reach a patient for emergent or scheduled services

September 2010

Manitoba
Health