

## Overview of the GCCH Resident Safety Incident Program

The Incident Reporting System is a management tool designed to collect information about unusual occurrences to:

- identify sources of harm to the resident or the residents' property;
- evaluate risks in terms of severity and frequency of occurrence;
- take appropriate action for those risks which can be eliminated;
- identify risks which cannot be eliminated but reduced in frequency and severity;
- establish preventative measures to prevent similar situations from reoccurring.

A comprehensive resident safety incident program is in place at the German - Canadian Care Home that supports reporting and learning; the organization has a Harm/No Harm/Near Miss Investigation and Disclosure Policy.

The Policy identifies the types of incidents:

- Harmful Incident: A Resident Safety Incident that results in harm to the resident(s). e.g., a resident fall with injury
- No Harm Incident: A Resident Safety Incident that reached a resident, but no discernible harm resulted. e.g., a resident fall without injury.
- Near Miss: A Resident Safety Incident that did not reach the resident. e.g., a medication error identified by the nurse before giving the medication to the resident.

Reportable incidents are reported to the funding agency and licensing (Vancouver Coastal Health Licensing and Vancouver Coastal Health Facility Liaison) and include Responsive/ Unusual Behavior, Aggression between persons in care, Attempted Suicide, Choking, Outbreak, Abuse, Neglect, Falls, Medication Error, Missing or Wandering Resident.

All staff are responsible for reporting incidents by completing an Incident Report Form for all incidents or near misses involving residents or their property.

The nurse is responsible for notifying the next of kin, the attending physician, external agencies (police, coroner, fire department and others as per legislation), the Director of Care and/ or the Chief Executive Officer.

Incidents are investigated by the responsible manager. Based on the findings a corrective action plan is developed. All reports are reviewed by the CEO.

Once the investigation is complete and the corrective action plan developed the resident and/or family is informed of the plan.

Information on follow-up action is shared with staff and with families as appropriate. Feedback is solicited from families and residents at the end of the investigation.

All incidents are tracked, reported monthly at management team meeting (DOC safety report) and stats on all incidents are reviewed and analyzed at quarterly QI team meetings.

The Chief Executive Officer submits a report to the Board of Directors of the key findings including a review of the information collected during the investigation, the initial and final understandings of the event, the contributing factors and root causes identified, the actions and implementation plan developed.