STONEY HEALTH SERVICES POLICY AND PROCEDURES		INCIDENT MANAGEMENT MASTER POLICY	
Effective: May 9, 2014	**Policy No.**: PP + TITLE	**Applies To**:	✓ Leadership & Operations ✓ Programs & Services
Review: May 27,2020	**Sheet:** 1 of 16		
Next Review: May 27,2023	**Approval:** ED		

Related Policies and Procedures: SHS Workplace Health & Safety Policy; SHS Emergency Response and Recovery Plan; SHS Medication Management Policy; SHS Infection Prevention and Control Policy**;** SHS Integrated Quality Management Policy

1. **INTRODUCTION**: Reporting of all incidents (Adverse Events, Sentinel Events and Near Misses) as well as the analysis, disclosure of harm (where appropriate) and resolution of the incident are all linked and will be treated together in this document.

2. **STANDARDS:**

   2.1. Incidents: Stoney Health Services (SHS) follows a formal Incident Reporting System for reporting of all incidents (adverse events, sentinel events, and near misses) as well as for conducting the appropriate follow-ups, investigations, corrective actions and documentation in the context of the SHS No-Blame culture of transparent reporting for learning and improvement. See Appendix II: SHS Incident investigation, Analysis and Resolution Process.

   2.2. Disclosure: Stoney Health Services (SHS) follows a formal and open policy and process for disclosure of adverse events to clients and families, including support mechanisms for clients, family, staff, and service providers involved in adverse events. As such, SHS has adopted the Canadian Patient Safety Institute's (CPSI's) Canadian Disclosure Guidelines with respect to reporting and disclosing events with implications for client care and/or safety.

3. **RATIONALE:**

   3.1. Reporting: In healthcare, safety incidents can and do occur despite our best efforts. They can and do negatively affect the lives of clients and families, as well as those of care providers and organizations providing care and services. Transparent reporting of safety incidents is strongly encouraged at SHS within the context of a 'just' and non-blaming culture where improving systems is the main objective and where all can feel that reporting is safe.

   3.2. Analysis: Learning from safety incidents is critical to the promotion of a safe environment for all SHS clients, personnel, medical staff and visitors; it is a way of improving not only our services, but client health outcomes as well. Objective and impartial analysis of safety incidents is necessary to enable us to learn from them and to adjust our systems to prevent safety incidents from recurring.

   3.3. Disclosure: Clients and their families are entitled to an accurate understanding of their care and services. Research shows a positive relationship between client satisfaction with how an adverse event is handled by an organization and formal open disclosure. Disclosing adverse events in an open and timely manner may maintain the client's relationship with the health service organization, staff and service providers, and reduce the risk of litigation. SHS is committed to open and honest communication between its service providers and clients' families in all aspects of care and service. This applies equally to the SHS Disclosure Process that is used when, despite our best efforts to provide safe, quality care, clients may sometimes experience harm.

4. **POLICY:** All managers, staff and contractors associated with SHS shall report any incident or near miss in writing on the Incident Reporting and Analysis form (See Appendix I) as soon as possible after the incident. All shall be provided the full support of SHS Leadership and are expected to collaborate in the subsequent improvement and disclosure processes outlined below to prevent and/or mitigate further harm from similar such incidents.

5. **PROCEDURE(S): The following seven (7) procedures and related appendices are outlined below:**

A. REPORTING INCIDENTS: All SHS personnel and contractors shall report all incidents in writing to their immediate superior on the SHS Safety Incident Reporting and Analysis Form (Appendix A); and, shall then collaborate fully in any ensuing investigation and improvements required to prevent further such incidents. The incident reporting and analysis process shall be conducted with respect for and attention to the privacy and confidentiality of the individuals involved in the incident as much as possible; the objective being to learn from the incidents in order to make improvements and prevent further harm.

Note: In the case of vehicular deficiency where no incident has been noted, a Vehicular Deficiency Report must be completed. (see Appendix IV.)

B. INVESTIGATING INCIDENTS:

B.1. Goals and Methodology: The three (3) goals of incident analysis are to determine: 1) what, how and why an incident happened; 2) what can be done to reduce the risk of recurrence and make care and services safer; and, 3) what else was learned that could help for further improve care processes and systems. With this in mind, the investigation of safety incidents shall:

B.1.1. Begin as soon as possible after the incident with a preliminary analysis;

B.1.2. Be objective, impartial and thorough;

B.1.3. Be participative, be supported by SHS leadership and involve SHS personnel, as needed, as well as the client and/or the family and any other persons associated directly or indirectly in the incident, if they are able to contribute;

B.1.4. Contain a detailed description of the incident being analyzed as well as an analysis of underlying systems issues (i.e. The "how", "why" and "what influenced the incident" questions) in order to determine contributing factors under control of SHS and those that are not on the SHS incident reporting and analysis form (Appendix I);

B.1.5. Consider relevant literature and other sources of information (e.g. clients' files, internal alerts, similar incidents, etc.);

B.1.6. Provide formalized recommendations and a related action plan that includes well-documented follow-though and communication strategies to address necessary systems improvements and share learning. Note: It is expected that investigators will provide their informed opinions and impressions, but these must be clearly stated as such

B.1.7. Note: See Appendix II: Incident Investigation, Analysis & Resolution Process

B.2. Roles & Responsibilities;

B.2.1. **The Safety Officer shall:**

B.2.1.1. Coordinate incident reporting, analysis, resolution and follow-ups in collaboration with SHS managers and personnel;

B.2.1.2. Present regular incident trend analysis reports to the ED, OHS Committee & SHS personnel;

B.2.1.3. Collaborate (or oversee, as the case may be) with incident investigations when required;

B.2.1.4. Ensure that all new personnel are oriented to incident reporting; and, update all personnel of pertinent changes in a timely manner.

B.2.2. **The Executive Director (ED) and his/her Executive Assistant shall:**

B.2.2.1. Ensure that the SHS Incident Reporting System is in compliance with the no-blame philosophy of SHS and with applicable legislation, within the protection afforded by said legislation;

B.2.2.2. Receive incident reports from personnel/contractors under his/her responsibility;

B.2.2.3. Support the reporting, investigative and disclosure processes; and, participate in ongoing discussions with SHS personnel about safety trends, related corrective measures and system improvements as part of SHS' ongoing Quality Improvement and Risk Management Strategy;

B.2.2.4. Support SHS personnel involved in reporting and/or investigating incidents;

B.2.2.5. Provide regular reports to the Stoney Tribal Administration (STA)

B.2.2.6. Act, as needed, as the instance of last resort for managers in decisions concerning corrective measures.

B.3. Managerial personnel and the Medical Director shall, for personnel under their responsibility:

B.3.1.1. Receive incident reports from personnel/contractors under his/her responsibility;

B.3.1.2. Respond to incident reports in a timely manner and on a case-by-case basis

B.3.1.3. Ensure that incident reports are clear and complete; and, that copies are provided to the Safety Officer in a timely manner;

B.3.1.4. Initiate the investigation and analysis of the incident;

B.3.1.5. Take steps to involve, protect and support implicated parties as needed;

B.3.1.6. Conduct the necessary follow-ups and corrective measures;

B.3.1.7. Document the process and provide any other necessary information to the ED; and, carry out systems improvements as needed in collaboration with SHS personnel (see Appendix I: Incident Reporting and Analysis Form).

B.3.1.8. Provide feedback to the Executive Director (and/or the Executive Assistant), the Safety Officer and pertinent SHS personnel to ensure that key information about the incident and related outcomes is shared in the spirit of learning and Quality Improvement to prevent further similar events.

C. DISCLOSURE OF HARM TO CLIENTS/FAMILIES:

C.1. Adverse Events: In the case of an adverse event involving a client (or family member), disclosure must occur if the client has experienced any harm, if there is a risk of potential harm in the future and/or there if is a significant change in care. Note: The only exception to this is the case where it is felt that this knowledge would be detrimental to the client (i.e. an individual who is paranoid may become even more so).

C.2. Near Misses: In the case of a near miss, disclosure may or may not occur based upon the discretion of the healthcare team as to whether or not the client would benefit from knowing or would want to know.

C.3. Preparing for Disclosure – Seven (7) Steps:

C.3.1. Review the Incident Report, agree upon the facts to be presented and decide how they will be presented (i.e. what will be said in what order etc.).

C.3.2. Determine where, when and how the disclosure discussion will be held.
(*NB: a quiet place, free from disturbance is preferable.)*

C.3.3. Determine who will coordinate the Disclosure process and related follow-ups.

C.3.4. Determine who will be the point of contact for the client and the family.

C.3.5. Determine who will lead the disclosure discussion.
(NB: The leader chosen should be the person best able to deliver a calm, clear message to the client in terms that are easy to understand and in a respectful, culturally-sensitive manner that is sincere, but free from emotion. He/she must avoid speculation or laying blame, be able to clarify the client's/family's understanding of the key messages provided and provide time for questions.)

C.3.6. Determine who else will be present (this depends upon the situation*)* and anticipate their support needs. (*NB: If concerned persons are prone to be emotional, it is preferable that they do not attend*.)

C.3.7. Anticipate and prepare for the client's emotional reaction.
(NB: Having a support person present for the client or an Elder from the community may be helpful.)

C.4. Carrying Out and Documenting the Disclosure - Ten (10) Steps:

C.4.1.1. Introduce all those present to each other and explain the reason for the meeting;
C.4.1.2. Describe the agreed-upon facts of the Incident and the outcomes, if they are known;
C.4.1.3. Describe what has been done for the client and further steps that will be taken, if needed;
C.4.1.4. Apologize using the words *'I am sorry that this happened to you...' ;*
C.4.1.5. Explain what can be expected as learning from the analysis of the incident and how you intend to prevent further harm from happening to other clients by improving how things work at SHS;
C.4.1.6. Invite the client and/or the family to ask questions and discuss their own point of view.
C.4.1.7. Review what was discussed and document it in the client's file; allowing the client to read it;
C.4.1.8. Offer to arrange further meetings or contacts to give the client updates on the progress of the investigation and/or improvement measures; and/or to provide access to spiritual or emotion support;
C.4.1.9. Reimburse any costs incurred by the disclosure process;
C.4.1.10. Facilitate and support ongoing incident analysis and treatment as needed.;
C.4.1.11. Document all of the above in the client's file.

D. SUPPORTING SHS PERSONNEL, PHYSICIANS AND CONSULTANTS AFFECTED BY SAFETY INCIDENTS: All SHS personnel and contractors shall be encouraged to play an active part in the investigation, follow-ups and systemic improvements related to incidents in which they are involved directly or indirectly. Staff and consultants will be heard with an open mind and treated with respect. They shall be provided with practical and emotional support as well as access to confidential Employee Assistance Services as needed.

E. MONITORING & ACTING ON SAFETY INCIDENT TRENDS: Incident trends are monitored at SHS on an ongoing basis (and are grouped according to the seven (7) following dimensions to reflect the SHS holistic, integrated Quality Improvement and Risk Management strategies.

E.1. Client Safety in all SHS sites (i.e. infection control), in the Home (i.e. falls) and in the Community (i.e. suicide risk);

E.2. Equipment Safety (i.e. faulty Home Care or Clinic equipment that is faulty);

E.3. Environmental Safety (i.e. Staff falling or being aggressed; heating system defects, etc.);

E.4. Infection Prevention and Control (i.e. needle-stick injuries);

E.5. Informational Safety (i.e. absence of or incomplete care plans; breaches of confidentiality; computer system 'downtimes', etc.);

E.6. Medication Safety (i.e. missed medication reconciliation, use of dangerous abbreviations, etc.);

E.7. Workplace Safety for SHS Personnel, Physicians and Consultants (i.e. disposal of hazardous material), in the Home (i.e. aggression risk) and in the Community (i.e. distracted driving).

F. REPORTING TO THE STONEY TRIBAL ADMINISTRATION (STA): The ED and or his delegate(s) supported by the Safety Officer shall present regular incident report trend analyses reports including related corrective actions taken and any further recommendations to the Stoney Tribal Administration.

G. TRAINING FOR SHS PERSONNEL: All SHS staff and contracted personnel shall receive training about adverse events and near misses. This begins at the time of orientation and continues with ongoing updates about the Incident Reporting System and current safety trends.

H. INDICATORS AND FORMULAE:

INDICATORS	CALCULATIONS
Rate of safety events with and without harm and near misses /quarter stratified by type (7 categories)	Number of safety events with / without harm and near misses x 100% Total Number of client safety events
Number of disclosures of harm	Total Number reported

I. DEFINITIONS (alphabetical order)

- **Adverse Event: "**...Results in unintended harm to the patient [client] and is related to the care and/or services provided to the patient [client] rather than to the patient's [client's] underlying medical condition". *(Accreditation Canada, 2006; Canadian Patient Safety Dictionary, 2003*).

- **Apology:** A genuine expression of sympathy and/or regret for something that harm has occurred. An apology may or may not include an acknowledgement of responsibility depending upon the results of investigation of the safety incident in question.

- **Client /Patient Safety Incident**: The World Health Organization defines a client/patient safety incident as an event or circumstance that could have resulted, or did result, in unnecessary harm to a patient. It includes harmful incidents (formerly adverse or sentinel events), no harm incidents (that reach the

patient but did not cause harm), and near misses (also known as close calls). Adapted from: Incident Analysis Collaborative Parties. (2012) Canadian Incident Analysis Framework; Canadian Patient Safety Institute. Edmonton, Alberta.

- **Disclosure:** The process whereby SHS Personnel 1) acknowledge to clients and/or their families that harm has inadvertently resulted from some aspect of care or services and is not related to the natural disease process, 2) apologize sincerely for this and 3) make a commitment to determine the facts and to share them as soon as possible with the client and/or family. Disclosure is the right thing to do; it is what any of us would expect given similar circumstances.

- **Distracted Driving:** Distracted driving refers to the act of driving while engaging in other activities which distract the driver's attention away from the road.

- **Harm:** An unexpected, unintended outcome event occurring in the context of care or services provided by SHS personnel that negatively affects the health or quality of life of any member of SHS personnel, medical staff, consultants, clients and/or their family members.

- **Harassment (and related terms)**: Harassment is a form of Workplace Violence; in the workplace, it is also a form of discrimination. For the purposes of this policy, harassment in the workplace includes personal and sexual harassment, poisoned work environment and abuse of authority. It includes objectionable conduct, comment or display made on either a one-time or continuous basis that demeans, embarrasses, humiliates or is known, or ought to be reasonably known and understood to be unwelcome. Harassment is unwelcome and unwanted; it affects the individual's ability to learn and work. It can also be an expression of abuse of power, authority, or control and is coercive in nature. Without limiting the above, harassment includes harassment on the basis of the following prohibited grounds of discrimination: race, colour, religion, national origin, and ancestry, place of origin, age, physical disability, mental disability, marital status, sexual orientation or sex. Note: Performance reviews, work evaluation and disciplinary measures taken by the employer for any valid reason do not constitute harassment in the workplace.

  a. Abuse of Authority: Harassment also includes abuse of authority where an individual improperly uses the power and authority inherent in a position to endanger a person's job, undermine the performance of that job, threaten the person's economic livelihood, or in any way interfere with or influence a person's career. It is the exercise of authority in a manner which serves no legitimate work purpose and ought reasonably to be known to be inappropriate. Examples of abuse of authority include, but are not limited to, such acts or misuse of power as intimidation, threats, blackmail or coercion.

b. Bullying: Bullying is different normal worker conflict in that it is negative and persistent abuse. Bullying is defined as repeated, persistent, continuous behaviour as opposed to a single negative act and is generally associated with a power imbalance between the victim and perpetrator, where the victim feels inferior (Salin 2003). Bullying in the workplace is often associated with poor management styles and/or lack of presence of management but should not be confused with tough management styles. The following are some examples of workplace bullying behaviours: social isolation (silent treatment), rumours, excessive or unjustified criticism, over-monitoring of work, verbal aggression, withholding information, replacing proper work with demeaning jobs and setting unrealistic goals or deadlines

c. Sexual harassment means any conduct, comment, gesture or contact of a sexual nature, whether on a one-time basis or a series of incident that might reasonably be perceived as placing a condition of a sexual nature on employment, an opportunity for training or promotion, receipt of services or a contract. Examples of behaviour that can constitute sexual harassment include, but are not limited to: unwanted touching, patting or leering, sexual assault, inquiries or comments about a person's sex life, telephone calls with sexual overtones, gender-based insults or jokes causing embarrassment or humiliation, repeated unwanted social or sexual invitations, and inappropriate or unwelcome focus/comments on a person's physical attributes or appearance.

c. Poisoned Work Environment: A poisoned work environment is characterized by an activity or behaviour, not necessarily directed at anyone in particular, that creates a hostile or offensive workplace. Examples of a poisoned work environment include, but are not limited to, propagation of gossip, graffiti, sexual, racial or religious insults or jokes, abusive treatment of an employee and/or client and/or the display of pornographic or other offensive material.

- **Hazard:** A circumstance or set of circumstances that, if left unchanged, could cause harm to contribute to harm.

- **Incident Analysis**: A structured process that aims to identify what happened, how and why it happened, what can be done to reduce the risk of recurrence and make care safer, and what was learned. The analysis always ends with recommendations for preventing further similar incidents.

- **Near Miss (Good Catch or Close Call)**: A safety incident that could have but did not impact negatively on the client, visitor and/or any member of SHS personnel, medical staff or consulting personnel. Replaces "close call". An event or circumstance which has the potential to cause serious physical or psychological injury, unexpected death, or significant property damage, but did not happen due to chance, corrective action, and/or timely intervention. NB: Estimated to be three times more prevalent than adverse events.

- **Safety Incident**: An incident that results in harm to the client, visitor and/or any member of SHS personnel, medical staff or consulting personnel. Safety incidents include "Adverse Events", "Sentinel Events" and "Near Misses". At SHS, we have divided these incidents into seven (7) categories (see table below), each of which can have a near miss, adverse event or sentinel event rating as well as being divided into subcategories (i.e. information safety: breaches of confidentiality, computer system downtime, etc.).

Incident Categories	Examples
Patient Safety	Client incidents are related to the care and/or services provided rather than to the client's underlying medical condition". They may also involve families and visitors. (i.e. falls, etc.)
Equipment Safety	Equipment incidents pertain to the use of any SHS equipment and/or vehicles used by SHS personnel (i.e. broken loaner equipment for clients, Medical Van breakdowns, faulty ventilation systems etc.)
Environmental Safety	Environmental incidents can include hazards (i.e. spills, floods, fires etc.) in or and/or in the immediate vicinity of SHS installations, and/or in clients' homes, and/or any location where SHS personnel may intervene.
Infection Prevention & Control	Infection prevention incidents pertain to wound infections, poor hand washing, needle puncture wounds etc.
Information Safety	Information incidents relate to breaches of confidentiality, computer system 'downtime' etc.
Medication Management Safety	Medication incidents include i.e. wrongly-filled dosettes, medication errors, improper use of high-risk precautions etc.)
Workplace Safety	Workplace incidents involve SHS personnel, physicians and/or contracted workers (i.e. verbal aggression, distracted driving etc.)

- **Workplace Safety**: The degree of security in the working environment that encompasses all factors which impact the safety, health, and well-being of the staff, clients, visitors, and consultants. A structured approach designed 1) to improve the safety and health for all workers, as evidenced by fewer hazards, reduced exposures, and fewer injuries, illnesses, and fatalities; 2) to change workplace culture to increase employer and worker awareness of, commitment to, and involvement in safety and health; and, 3) to secure public confidence through excellence in the development and delivery of programs and services.

- **Workplace Violence (see Also 'Harassment and Related Terms'):** The literature recognizes four (4) types of workplace violence as listed below:

- ☐ Type I (Criminal Intent): The perpetrator has no relationship to the worker or the workplace
- ☐ Type II (Client or Customer): The perpetrator is a client at the workplace who becomes violent toward a worker or another client
- ☐ Type III (Worker-to-worker): The perpetrator is an employee or past employee of the workplace.
- ☐ Type IV (Personal Relationship): The perpetrator has a personal relationship with an employee or a client, e.g., domestic violence.

Workplace Violence includes but is not limited to 1) the use of physical force against or by SHS staff and/or clients that causes or could cause physical injury; including but not limited to, physical acts such as punching, hitting, kicking, pushing, damaging property or throwing objects; 2) the attempted use of physical force against or by SHS staff and/or clients that could have caused physical injury; 3) a gesture, action or statement (or series of gestures, actions or statements) reasonably believed to be a threat of physical harm or as a threat to safety or security in the workplace; and 4) bringing a weapon (or an object that could be used as a weapon) of any kind to a SHS workplace or possessing or threatening to have/use a weapon of any kind while SHS services are being carried out.

8. REFERENCES:

- Baker et al (2004)," Canadian Adverse Events Study"
- Alberta Health Services (2012) Policy: Reporting of Clinical, Adverse Events, Close Calls and Hazards
- Alberta Health Services (2012) Policy: Disclosure of Harm
- Accreditation Canada Glossary (2006)
- Accreditation Canada (2014) Required Organizational Practices
- Canadian Patient Safety Dictionary (2003)
- Canadian Patient Safety Institute (2011), Canadian Disclosure Guidelines
- Canadian Patient Safety Institute (2012), Canadian Incident Analysis Framework
- Health Quality Council of Alberta (2014), Checklist for Disclosure Team Discussion

9. RESPONSIBILITIES

A. The Executive Director shall ensure the approval of this policy.

B. SHS Managers/Supervisors and the Medical Director shall jointly ensure the application of this policy.

C. All SHS personnel and contractors shall comply with this policy.

10. REVISED BY:

A. Malimban, Homecare Manager	October 19, 2018
D. Richter , Nursing Manager	October 19,2018
C. Meert, Manager Administrative Services	October 19, 2018
B. Hancock, Safety Officer	October 18 & May 27,2020

11. APPROVALS:

A. Khan
Executive Director

Date

APPENDIX I: STONEY HEALTH SERVICES INCIDENT REPORTING AND ANALYSIS FORM
(Revised Nov. 20,2019)

CODE: F-TITLE	STONEY HEALTH SERVICES: INCIDENT REPORTING & ANALYSIS FORM						
Effective	July 1 ,2018	Revision	Nov. 20,2019	Next Revision	Nov. 20,2022	Approval	A. Khan

SECTION A: INCIDENT REPORT

Sections A to be completed by the person involved and/or witness as soon as possible after the incident & submitted digitally to the Manager and Safety Officer. The full report & analysis (sections A & B) is to be sent to the Exec. Assistant of the ED and the Safety Officer by the Investigator upon completion.

Submitted by: Click or tap here to enter text.	**Department:** Click or tap here to enter text.

1. Background Information

Name of Client(s) / Individual(s) Involved: Click or tap here to enter text.	Age: ?	Address & Contact Number of Client(s) / Individual(s) Involved: Click or tap here to enter text.
Date of Incident: Click or tap here to enter text.	Time: ?	Location of Incident: Click or tap here to enter text.
Witness/Author: Click or tap here to enter text.	Relationship: ?	Contact Information: Click or tap here to enter text.
Pre-existing Health Conditions/Illnesses/Problems: Click or tap here to enter text.		
Medications Currently Used *(NB: Attach current medication list)*: Click or tap here to enter text.		

2. Incident Type *(Check One)* ☐ Adverse Event ☐ Near Miss

3. Incident Category *(Check One)*

☐ Client Safety	☐ Fall - No Consequences	☐ Infection Prevention & Control
	☐ Fall - With Consequences	☐ Informational Safety
	☐ All Other Client Safety Issues	☐ Medication Safety
☐ Environmental Safety *(Add Location)*		☐ Workplace Safety
☐ Equipment Safety *(Add type of equipment)*		☐ Other *(i.e. Client complaint, community issue etc.)*

4. Description of incident and state of person(s) involved. *(i.e. what, how, when, where, why and contributing factors). Attach photos as required. If more space needed, continue on reverse side of sheet.*

Click or tap here to enter text.

5. Immediate Actions Taken and Results *(Describe clearly)*

Click or tap here to enter text.

Name (Block Letters) & Signature of Reporter: Click or tap here to enter text.	Date: ?	Time : ?
Name (Block Letters) & Signature of Manager/Supervisor: Click or tap here to enter text.	Date: ?	Time: ?

Copies Sent to: ☐ Manager / Supervisor ☐ Safety Officer ☐ Other: Click or tap here to enter text.

CODE: F-TITLE	STONEY HEALTH SERVICES: INCIDENT REPORTING & ANALYSIS FORM						
Effective	July 1 ,2018	Revision	Nov. 20,2019	Next Revision	Nov. 20,2022	Approval	A. Khan

SECTION B: INCIDENT ANALYSIS

1. Stabilization of Situation *(Describe actions taken to reduce harm and ensure safety of client/ person involved)*

Click or tap here to enter text.

2. Investigation *(Describe key events & timeline of incident, conduct interviews, consult key documents etc. **NB**: For Falls/Near Falls, complete Section 3 below and/or refer for Multifactorial Risk Assessment, as required)*

Click or tap here to enter text.

3. Specific to Falls *(Review & summarise impacts of the following elements likely to increase):*

a. Underlying conditions/illness(es) / problems: Click or tap here to enter text.

b. Medications: Click or tap here to enter text.

c. Environmental conditions: Click or tap here to enter text.

d. Functional, sensory, nutritional and/or psychological status: Click or tap here to enter text.

e. Fall- risk factors: Click or tap here to enter text.

4. Analysis & Conclusion *(Provide an informed impression of incident as well as of contributing and causal factors*

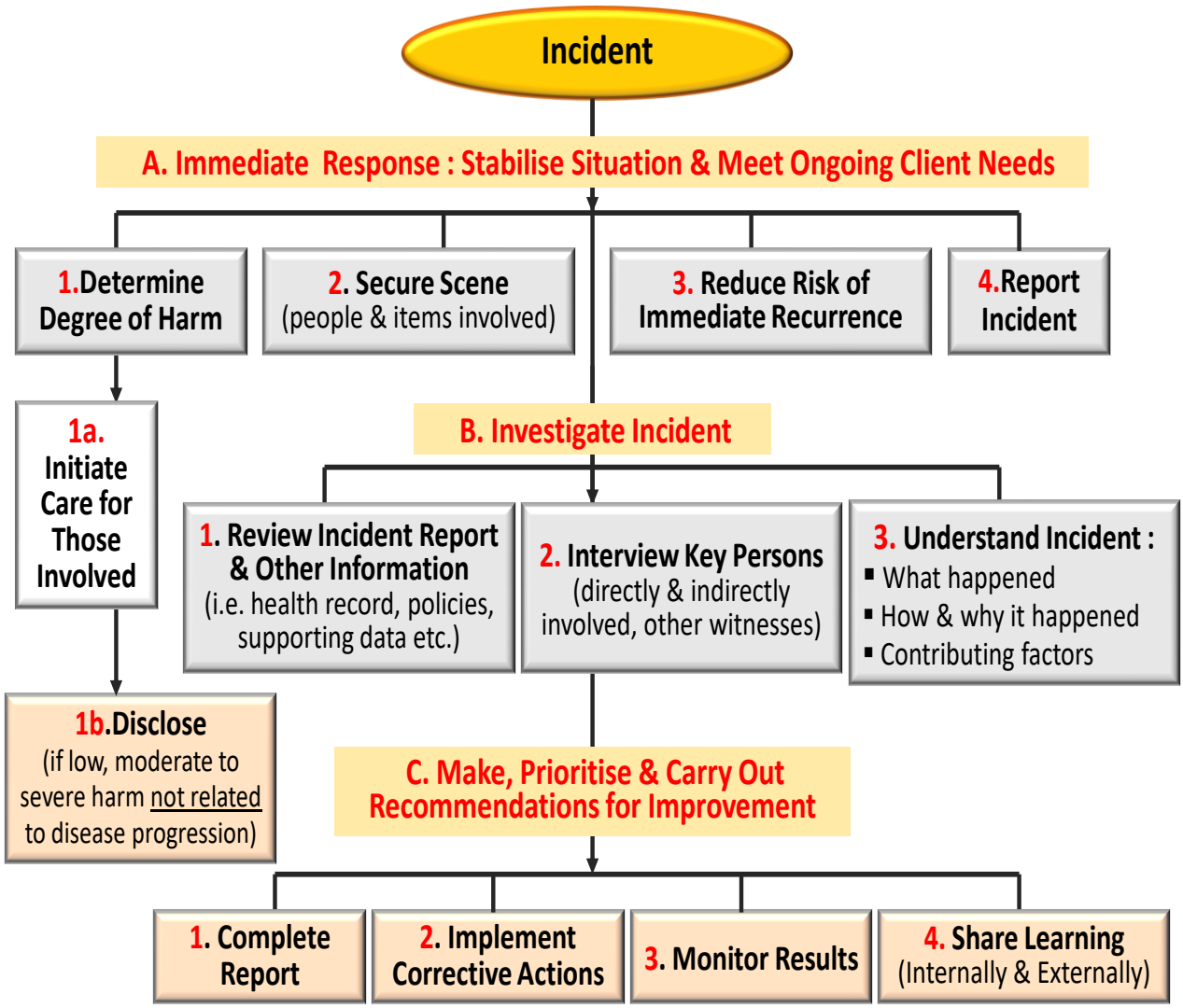
Click or tap here to enter text.

5. Recommendations *(Provide situation-specific and system-wide recommendations, if appropriate to prevent further risk and harm)*

Click or tap here to enter text.

Signature of Investigator:	Date: ?	Time: ?
Signature of Executive Director:	Date: ?	Time: ?

APPENDIX B: SHS INCIDENT INVESTIGATION, ANALYSIS AND RESOLUTION PROCESS



Adapted from the Canadian Patient Safety Institute (2013), Canadian Incident Analysis Framework

APPENDIX C: DISCLOSURE TEAM DISCUSSION CHECK LIST

CODE: F + TITLE	STONEY HEALTH SERVICES: DISCLOSURE DISCUSSION CHECKLIST						
Effective	July 1 ,2018	**Revision**	May 22,2020	**Next Revision**	May 22,2023	**Approval**	**A. Khan, ED**

Introduction: This checklist is useful for identifying tasks to be completed or delegated during a meeting of the disclosure team prior to speaking with the client and/or his/her family/support person(s); the latter, only with the permission of the client. The support person(s) may be any individual the client identifies as the nominated recipient of information about his/her care and may include family, a friend, a partner or those caring for the client. In cases of a dispute between family and partners or friends about who should receive information, the client's expressed wishes are paramount.

Check When Completed	Yes	No
1. All relevant health care professionals involved in the adverse event have been notified/consulted.		
2. Establish and agree upon known facts: Don't include speculation, opinion or blame.		
3. Identify person(s) to take responsibility for the initial disclosure conversation with the client/family: • *Known to the client* • *Familiar with the incident and care of the client/family* • *Good interpersonal and communication skills* • *Willing to maintain a relationship with the client/family* • *Received disclosure training*		
4. Name of Disclosure Leader(s):		
5. Identify a location and time for disclosure:		
6. Designate a point of contact for the client (if not the client themselves):		
7. Support person(s) (e.g., family member) for client identified and available: Name(s): Relationship to client:		
8. Identify and offer support for the disclosing health professional.		
9. Consider the appropriate timing of the initial discussion (as soon as possible following discovery of harm) taking into account the following and any other pertinent factors: • Client's physical, emotional & psychological states • Client's comfort & preferences • Availability of client's support person(s) • Availability of key staff & supports		
10. Special consideration or support required.		
11. Ongoing clinical needs managed.		
Checklist Completed by: **Date:**		

APPENDIX D: VEHICULE DEFICIENCY REPORT

CODE: F + TITLE	STONEY HEALTH SERVICES: VEHICLE DEFICIENCY REPORT FORM						
Effective	Dec. 18,2019	**Revision**	May 27,2020	**Next Revision**	May 27,2023	**Approval**	**A. Khan**

Date: Click or tap here to enter text.	Time: Time	Vehicle Number: Click or tap here to enter text.
Name of Reporter: Click or tap here to enter text.	Location of Vehicle: Click or tap here to enter text.	
1. Deficiency Type *(Check all that apply & and add explanatory comments below)*		
Comments: Click or tap here to enter text.		
2. Actions Taken and Results *(Describe clearly. Attach any pertinent invoices)*		
Click or tap here to enter text.		

Signature of Reporter: Click or tap here to enter text.	Date: ?	Time: ?
Name (Block Letters) & Signature of Manager of Administrative Services: Click or tap here to enter text.	Date: ?	Time: ?
Name (Block Letters) & Signature of Executive Director: Click or tap here to enter text.	Date: ?	Time: ?

Invoice Attached :	☐ YES	☐ NO	
Copies Sent To	☐ Manager	☐ Safety Officer	☐ Other (Specify): ?