UVic in Partnership with Camosun College BSN Program

Student and Patient Critical Incident Reporting and Learning Form

"Learning Together: To Foster a Culture of Safety" BC-PSLS

Our approach: A positive and supportive approach to follow-up conversations after a critical incident that impacts the safety of those who provide care with those who receive care, and promotes a non-blaming and just culture. **This form** is for all UVic in Partnership with Camosun BSN students in their practice experiences to record **three categories** of incidents: student critical incident (e.g., fall/needle stick injury/experiences of racism & bullying), patient critical incident (e.g., medication error/fall), and relational critical incident (e.g., racism, violence). **Refer** to the relevant practice handbook(s) for details, complete relevant learning activities, and ensure you have met the agency's policies following an incident. Refer to the UVic SON Incident Report Guideline for additional information.
Information on this form will be analyzed and findings will be used to guide learning and inform program improvements.

1. Student and UVic educator complete Incident Reporting and Learning Form as soon as possible following the critical incident.
2. The UVic educator signs and sends the Incident Reporting and Learning Form via email to the Practice Education Coordinator. Password protect the document.

Primary details of critical event	***Date of critical event (dd/mon/yy):***	***Date of discovery/reporting (dd/mon/yy):***	***Type of event:*** ◯ Near miss ◯ Level: ____ **see page five for the level rankings*	***Practicum:*** Course number: Practicum location: Shift: ☐ 12-Hour ☐ 8-Hour // ☐ Day ☐ Evening ☐ Night
	Who did the incident impact? ☐ Student ☐ Patient ☐ Staff ☐ Visitor ☐ Volunteer ☐ Property ☐ Other:			
	Discovered by: ☐ ***Name & position (print):*** ***Reported by:*** ☐ ***Name & position (print):***			***Signature:***
	Witnessed by:	***Name & position (print):***		***Signature:***
Category 1: **Student critical incident**	***Type of injury, accident or exposure:*** ☐ Needle puncture ☐ Exposure to infectious disease ☐ Musculoskeletal injury ☐ Fall (e.g., fainting, slip) ☐ Assault by patient ☐ Other			***Was data from this event submitted electronically through a WorkSafe BC Form #7?*** ◯ Yes ◯ No
Category 2: **Patient critical incident**	***Patient Fall*** ☐ Observed ☐ Unobserved	***Was orientation a factor in the fall?*** ☐ ***Yes*** ☐ ***No*** ☐ Alert/normal ☐ Anaesthetized ☐ Disoriented ☐ Sedated ☐ Other: ***Was ambulatory status a factor in the fall?*** ☐ ***Yes*** ☐ ***No*** ☐ Unlimited ☐ Needs assistance ☐ Bathroom privileges ☐ Urinary catheter ☐ Non-ambulant ☐ Restraints ☐ Other: ***Was patient environment a factor in the fall?*** ☐ ***Yes*** ☐ ***No*** If yes, (e.g., bed height, side rails, call bells), describe in reflection section.		
	Medication (check all that apply)	Near Miss ☐ Missed Medication ☐ **Incorrect:** ☐ Client ☐ Dose ☐ Route ☐ Time ☐ Medication ☐ Reason ☐ Documentation Other/details:		
Category 3: Relational Critical Incident	**Incidents associated with identity** of patient, visitor, student, and/or staff, e.g., relational or systemic racism, horizontal violence.			
Other	☐ Other Injury ☐ Procedural ☐ Hospital/patient property ☐ Safety security ☐ Other:			
Follow-up action taken	***Immediate:***			***Long term:***
BC PSLS	***Was data from this event submitted through the BC Patient Safety and Learning System (PSLS)?*** ☐ Yes ☐ No			

Student's reflection and learning:

Provide a concise description of the critical incident. What do you understand as contributing to the incident? Please reflect on individual, procedural, environmental, and system level factors. For example, consider communication and intersections of identity that contribute to relational incidents. A constellation diagram (also called a mind map) is a useful tool to help you work your way through this reflection. You will find more details on how to complete a constellation diagram in the student and educator critical incident learning modules. Attach more paper if necessary.

What were the potential outcomes to the patient that did or could have resulted from this incident?

What have you learned about yourself, your nursing practice, and the environment in which you are practicing?

How could an incident like this be prevented in the future? Use your completed constellation diagram to identify recommended changes or actions (from individual, procedural, environmental, and systems perspectives).

University/College Educator comments:

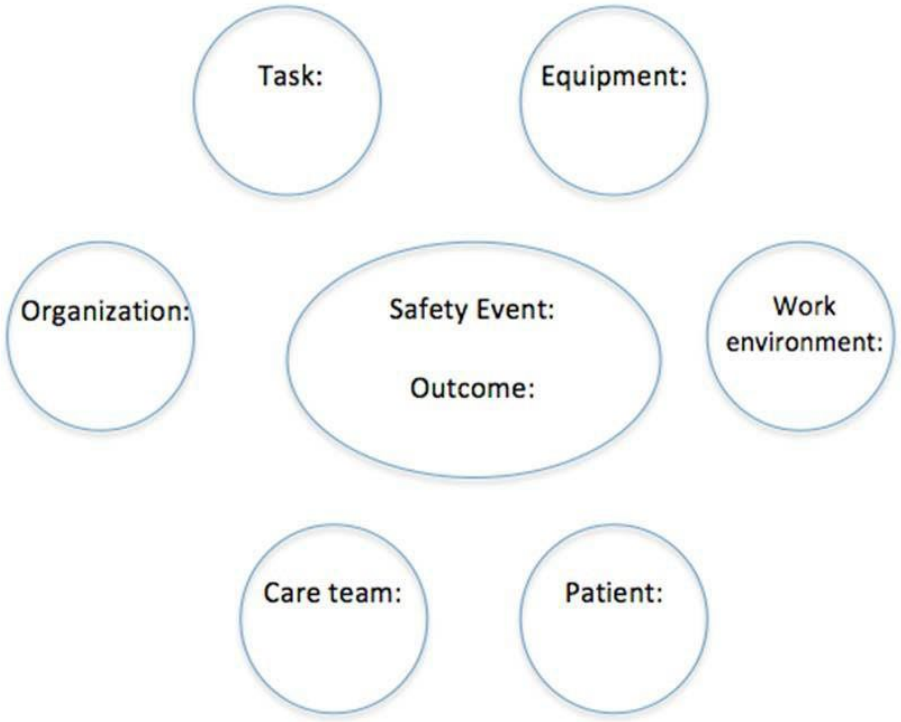
Student name: *(Please print)* Date: Time: Signature:	**University/College Educator name:** *(Please print)* Date: Time: Signature:	**Practice Ed Coordinator name:** *(Please print)* Date: Time: Signature:

WORKSHEET: Incident Analysis Using a Constellation Diagram

Incident analysis is 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. It is a systematic method to support a detailed and in-depth study of an incident. It helps you to think outside your usual thought patterns by suggesting possible—and possibly multiple—factors that contribute to an incident.

A constellation diagram is one such method. Think of the diagram as a mind map showing the interconnections between multiple causes and effects. The identified incident is the effect. Now, what are the causes or contributing factors? Below you will see some of the common categories of causes that contribute to incidents. Your focus is to think about possible causes and fill in the categories with as much detail as possible. Add your own categories to make sure you identify causes specific to your situation and context. Show connections between causes and categories.

Key resource: Canadian Safety Event Analysis Framework
http://www.patientsafetyinstitute.ca/English/toolsResources/IncidentAnalysis/Pages/default.aspx



BC Patient Safety Learning System (PSLS) Degrees of Harm

Near Miss — Event that could have caused harm, but is noted before it reaches the patient.

Level 1 — No Harm—unexpected, undesired event directly associated with care or services reaches patient but no harm/injury occurs

Level 2 — Minor Harm—unexpected, undesired event directly associated with care or services reaches the patient resulting in harm that requires local, short-term treatment

Level 3 — Moderate Harm—unexpected, undesired event directly associated with care or services reaches patient resulting in harm that requires ongoing additional treatment or admission to higher level of care

Level 4 — Severe Harm—unexpected, undesired event, where care or services directly casues or was strongly correlated with harm to the patient. Severe harm is understood as any physical or psychological injury which on a permanent or long-term basis substantially interferes with the person's functional abilities or quality of life, and causes the person to suffer pain or disfigurement, require major surgical or medical treatment, and require emergency medical treatment to prevent death, or have a shortened life expectancy

Level 5 — Death—unexpected, undesired event directly associated with care or services reaches the patient resulting in or significantly contributing to the patient's death