Practice Education Guidelines for BC
Safety Event/Incident Reporting

August 2021

Intent / Purpose

- Ensure Post-Secondary Institution (PSI) Students and Educators are included in creating a culture of safety within Health Care Organization (HCO) practice education settings.
- Outline the roles and responsibilities for reporting and investigating safety events (safety hazard or patient safety incident) witnessed by, discovered by, or involving Students and Educators that occur within a HCO practice education setting.

Definitions

Refer to: *Standard Terms and Abbreviations*

Culture of Safety	"…refers to people's shared values (what is important) and beliefs (what is held to be true), which interact with an organization's structure or system to produce behavioural norms (what people do)."[1]
Disclosure	"The process by which a patient safety incident is communicated to the patient by health care providers."[2]
Hazard	"Situations with the potential to cause harm"[3] "…any source of potential damage, harm or adverse health effects on something or someone."[4] "A set of circumstances or a situation that cause risk of harm or injury to patients, staff, or others, but where no specific patient, client, or resident was involved."[5] Types of hazards: chemical, ergonomic, health, physical, psychological, safety, workplace[6]
Health and Safety Standards	All Applicable Laws, standards of practice and codes of ethics issued by any professional regulatory body, and all rules, policies and regulations in place at the HCO or its Facilities that apply to the Students or Educators at the Facilities, any of which relate to workplace safety, the delivery of Health Care Services or the health and safety of HCO Clients or Workers.[7]
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."[8]
Incident Reporting	"The communication of information about a patient safety incident through appropriate channels inside or outside of healthcare organizations, for the purpose of reducing the risk of occurrence of patient safety incidents in the future."[9]
Patient Safety	"The pursuit of the reduction and mitigation of unsafe acts within the health care system, as well as the use of best practices shown to lead to optimal patient outcomes."[10]

[1] Canadian Patient Safety Institute (CPSI). (2016). *Engaging Patients in Patient Safety – a Canadian Guide: Glossary of Terms.* Retrieved on July 30, 2019 from https://www.patientsafetyinstitute.ca/en/toolsResources/Patient-Engagement-in-Patient-Safety-Guide/Pages/Glossary-of-Terms.aspx
[2] CPSI. *Patient Safety and Incident Management Toolkit – Glossary.* Retrieved July 30, 2019 from https://www.patientsafetyinstitute.ca/en/toolsResources/PatientSafetyIncidentManagementToolkit/Pages/Glossary.aspx
[3] Ibid.
[4] Canadian Centre for Occupational Health and Safety (CCOHS). (2019). *OSH Answers Fact Sheets – Hazard Identification.* Retrieved July 30, 2019 from https://www.ccohs.ca/oshanswers/hsprograms/hazard_identification.html
[5] BC PSLS Central (Producer). (2017). *Reporting Patient Safety Events in BCPSLS* [PSLS Reporter Training Video]. Retrieved July 30, 2019 from https://youtu.be/1f9l-EbD4Sc
[6] CCOHS. (2020). *Hazards.* Retrieved December 30, 2020 from https://www.ccohs.ca/topics/hazards/
[7] Health Care Protection Program. (2008). *Risk Note: Managing Risk in Educational Affiliation Agreements - Educational Institution Affiliation Agreement Template.* Retrieved October 27, 2020 from https://www.hcpp.org/?q=node/17
[8] CPSI. *Patient Safety and Incident Management Toolkit – Glossary.*
[9] Ibid.
[10] Ibid.

Patient Safety Incident	"An event or circumstance which could have resulted, or did result, in unnecessary harm to a patient. There are three types of patient safety incidents:
Harmful incident	A patient safety incident that resulted in harm to the patient. Replaces *preventable adverse event*
Near miss	A patient safety incident that did not reach the patient and therefore no harm resulted. [Other terms: good catch, close call]
No-harm incident	A patient safety incident that reached the patient but no discernible harm resulted."[11]

Practice Education Guidelines

PSIs maintain third party liability insurance coverage including malpractice and/or professional liability insurance for both Students and Educators as required by the HCO (see *Educational Institution Affiliation Agreement Template*).[12]

Contractors/Vendors who supervise Students within or on behalf of the HCO for any portion of the practice education experience maintains third party liability coverage that include Students as agents of the Contractor/Vendor (such as Commercial General Liability, Automobile Liability, and Professional Liability or Errors and Omissions insurance)[13, 14] (see *PEG Contractor/Vendor Practice Education Experiences*).

All parties involved in practice education (Students, PSI Educators, HCO Workers, and Contractors/Vendors) have a role in promoting an overall culture of safety and Client safety within the practice education setting by:

- following safe work practices
- identifying any risks for patient safety incidents and safety hazards
- taking action to prevent harm

HCOs welcome the reporting of safety events by PSI Students or Educators and use the information for quality improvement, incident analysis, and learning; not for punitive purposes.

[11] CPSI. (2016). *Patient Safety and Incident Management Toolkit – Glossary.*
[12] Health Care Protection Program. (2008). *Risk Note: Managing Risk in Educational Affiliation Agreements - Educational Institution Affiliation Agreement Template.* Retrieved October 27, 2020 from https://www.hcpp.org/?q=node/17
[13] Provincial Health Services Authority. (2020). *PHSA 02921 Request for Pre-Qualification for General Health Care and IMIT Consulting Services, Exhibit 5: Contact Terms and Conditions for General Health Care Consulting Services and IMIT Consulting Services.* Retrieved November 19, 2020 from https://www.bcbid.gov.bc.ca/open.dll/welcome?language=En
[14] Healthcare Insurance Reciprocal of Canada. (October 2017). *Contracts - Education Affiliation Agreements.* Retrieved March 18, 2021 from https://www.hiroc.com/resources/risk-notes/contracts-education-affiliation-agreements

Students who witness, discover, are involved in or responsible for any safety event that could have resulted, or did result, in unnecessary harm while in a HCO practice education setting:

- Take action to intervene, if necessary.
- Promptly report the event to their on-site PSI Educator, their HCO Supervisor, or the HCO Worker responsible for the area.

HCO Supervisors/Workers who receive reports of safety events from Students use the HCO process (such as BC Patient Safety Learning System [BCPSLS][15] or HAÍŁCÍSTA incident reporting and management system[16]) for reporting patient safety incidents[17] and/or safety hazards (such as a Workplace Hazard Report Form).[18,19,20]

PSI Educators who witness, discover, are involved in, responsible for, or receive reports of from Students about, any safety event that could have resulted, or did result, in unnecessary harm while in a HCO practice education setting:

- Take action to intervene, if necessary.
- Promptly report the event using the HCO process for reporting patient safety incidents and/or safety hazards.

Any PSI Student or Educator responsible for any safety event that could have resulted, or did result, in unnecessary harm while in a HCO practice education setting, also reports the event as soon as possible using the PSI process.

The PSI immediately reports to the HCO Practice Education Coordinator any incident taking place within the HCO involving its Students or Educators that causes or compromises the mental or physical health and safety of HCO Clients or Workers, or members of the public, including breaches of the Health and Safety Standards (see *Education Affiliation Agreement Template*).[21]

[15] BCPSLS Central. (n.d.) *What is BCPSLS?* Retrieved July 30, 2019 from https://bcpslscentral.ca/faqs/
[16] First Nations Health Authority. (2020). *2019/2020 Annual Report*. Pg. 68. Retrieved December 30, 2020 from https://www.fnha.ca/Documents/FNHA-Annual-Report-2019-2020.pdf
[17] Canadian Patient Safety Institute (CPSI). (2016). *Patient Safety and Incident Management Toolkit – Glossary*. Retrieved July 30, 2019 from https://www.patientsafetyinstitute.ca/en/toolsResources/PatientSafetyIncidentManagementToolkit/Pages/Glossary.aspx
[18] Ibid.
[19] Canadian Centre for Occupational Health and Safety. (2019). *OSH Answers Fact Sheets – Hazard Identification*. Retrieved July 30, 2019 from https://www.ccohs.ca/oshanswers/hsprograms/hazard_identification.html
[20] BC PSLS Central (Producer). (2017). *Reporting Patient Safety Events in BCPSLS* [PSLS Reporter Training Video]. Retrieved July 30, 2019 from https://youtu.be/1f9l-EbD4Sc
[21] Health Care Protection Program. (2008). *Risk Note: Managing Risk in Educational Affiliation Agreements - Educational Institution Affiliation Agreement Template.* Retrieved October 27, 2020 from https://www.hcpp.org/?q=node/17

If the PSI identifies a Student or Educator who poses or could pose a health and safety risk to HCO Clients or Workers, or members of the public, the PSI immediately advises the HCO Practice Education Coordinator and, if necessary to protect others, has the authority to suspend the Student's or Educator's participation in the education program (see *Educational Institution Affiliation Agreement Template; PEG Student Practice Issues*).[22]

HCOs has the authority to suspend or exclude a PSI Student or Educator from the practice education setting either temporarily (pending investigation) or permanently where the HCO or PSI has identified that the Student or Educator failed to comply with the Health and Safety Standards (see *Educational Institution Affiliation Agreement Template*).[23]

PSI Students and/or Educators take part in the follow-up debriefing, and incident analysis by the HCO when appropriate and invited to do so.

PSIs, Students, and Educators protect the privacy and confidentiality of information related to safety events (see *PEG Privacy and Confidentiality*).

Roles, Responsibilities and Expectations

Post-Secondary Institutions

- Establish and communicate policies, standards, guidelines, and protocols for safe work practices and reporting safety events during practice education experiences.
- Monitor reported safety events involving Students or Educators during practice education experiences in order to identify opportunities to improve the education program and prevent similar events in the future.
- Inform the HCO Practice Education Coordinator and/or practice education setting manager of Students' or Educators' expressed concerns regarding any work practices or activities taking place within the HCO causing or could potentially cause harm, including, but not limited to, breaches of Health and Safety Standards.

[22] Health Care Protection Program. (2008). *Risk Note: Managing Risk in Educational Affiliation Agreements - Educational Institution Affiliation Agreement Template.* Retrieved October 27, 2020 from https://www.hcpp.org/?q=node/17
[23] Ibid.

Students

- Use safe work practices.
- Take action to prevent safety events (patient safety incidents or safety hazards), and intervene as necessary if it can be done safely.
- Promptly report any witnessed, discovered, or involvement in a safety event to the PSI Educator or HCO Supervisor/Worker.
- Follow the policies, guidelines, and processes for recording and reporting patient safety incidents or safety hazards for the:
  - HCO (such as the BC PSLS or HAÍłCÍSTA, and Workplace Hazard Report Forms)
  - PSI (when appropriate)
- Take part in the HCO safety event reporting process with or under the direction of the PSI Educator or HCO Supervisor as needed.
- Take part in follow-up debriefing and incident analysis by the HCO and/or PSI as needed.
- In the event of an injury or exposure as a result of a patient safety incident or safety hazard, follow the process outlined in the Practice Education Guideline *Injury and Exposure During Practice Education Experiences*.

Health Care Organizations

- Identify and eliminate or control safety and health hazards in the workplace.
- Establish and communicate policies, standards, guidelines, and protocols for reporting patient safety incidents and safety hazards within the HCO.
- Provide Students and Educators with information on the processes for patient safety incident and safety hazard reporting as part of orientation to the practice education setting (see *PEG Orientation – Students*; *PEG Orientation On-Site Post-Secondary Institution Educators*).
- Provide on-site PSI Educators with access to the HCO incident reporting system, as appropriate.
- Involve the PSI, Student, and/or Educator in the incident analysis as appropriate.
- Take corrective actions to prevent further occurrences where appropriate.
- Include Student- and/or Educator-involved safety events in overall data analysis and reporting of safety events.

- Alert PSIs to any:
  - practices or activities by Students and/or Educators within the practice education setting that could potentially cause harm
  - trends related to Student- and/or Educator-involved safety events

PSI Educators / HCO Supervisors

- Create and sustain a supportive learning environment where PSI Students feel safe to express their learning needs and limitations.
- Create a culture of safety where the Student feels welcome to examine systems and factors affecting safety, identify potential risks, and take action as needed.
- Promptly report safety events according to the HCO policies, guidelines, and processes.
- Involve the Student in the HCO safety event reporting processes.
- Disclose the event to the Client as appropriate and according to HCO policy.
- Review relevant Student documentation, including in the HCO Client's health record, to ensure it is accurate and complete (see *PEG Documentation by Students*).
- Report to the PSI as soon as possible when a Student is directly involved in a safety event according to the PSI policies, guidelines, and processes.
- Debrief the event with the Student as appropriate.
- Take part in any follow-up and incident analysis by the HCO and/or PSI as needed.

References and Resources

BCPSLS Central (Producer). (2017). *Reporting Patient Safety Events in BCPSLS* [PSLS Reporter Training Video]. Retrieved July 30, 2019 from https://youtu.be/1f9l-EbD4Sc

Ibid. (n.d.) *What is BCPSLS?* Retrieved July 30, 2019 from https://bcpslscentral.ca/faqs/

Canadian Centre for Occupational Health and Safety. (2019). *OSH Answers Fact Sheets – Hazard Identification.* Retrieved July 30, 2019 from https://www.ccohs.ca/oshanswers/hsprograms/hazard_identification.html

Ibid. (2020). *Hazards.* Retrieved December 30, 2020 from https://www.ccohs.ca/topics/hazards/

Canadian Patient Safety Institute (CPSI). (2016). *Engaging Patients in Patient Safety – a Canadian Guide: Glossary of Terms.* Retrieved on July 30, 2019 from https://www.patientsafetyinstitute.ca/en/toolsResources/Patient-Engagement-in-Patient-Safety-Guide/Pages/Glossary-of-Terms.aspx

Ibid. *Patient Safety and Incident Management Toolkit – Glossary.* Retrieved July 30, 2019 from https://www.patientsafetyinstitute.ca/en/toolsResources/PatientSafetyIncidentManagementToolkit/Pages/Glossary.aspx

First Nations Health Authority. (2020). *2019/2020 Annual Report.* Pg. 68. Retrieved December 30, 2020 from https://www.fnha.ca/Documents/FNHA-Annual-Report-2019-2020.pdf

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Provincial Health Services Authority. (2020). *PHSA 02921 Request for Pre-Qualification for General Health Care and IMIT Consulting Services, Exhibit 5: Contact Terms and Conditions for General Health Care Consulting Services and IMIT Consulting Services.* Retrieved November 19, 2020 from https://www.bcbid.gov.bc.ca/open.dll/welcome?language=En

Guideline Review History

Version	Date	People Responsible	Brief Description (reason for change)
1	March 2007	Authors/Editors: Carol A. Wilson (BCAHC), Barb Collingwood (BCAHC) Reviewers: Practice Education Committee of the BC Academic Health Council (Grace Mickelson, Chair)	
2	March 2013	Editors: Diana Campbell (VIHA) Heather Straight (VCH), Andrea Starck (NHA) Deb McDougall (BCAHA), Carmen Kimoto (VCC)	Removed reference to student/PSI educator injury (created separate guideline – Injury and Exposure to Blood & Body Fluids) Refined content to align with title of reporting Adverse Events and Hazards Updated content/process to include PSLS Outdated References removed; PSLS reference added.
3	March 2021	Editor: Carol A. Wilson (PHSA) Reviewers: Judy Lee (KPU) BJ Gdanski (PHSA) Ministry of Health (Allied Health Policy Secretariat and Nursing Policy Secretariat) Ministry of Advanced Education, Skills and Training (Health Education Reference Committee) Health Authority Practice Education Committee	Updated title and terms to be consistent with the Canadian Patient Safety Institute Update references Updated guidelines to be broader than just applying to Health Authority, knowing that practice education experiences take place in a variety of settings, some of which do not use the BC PSLS (including removing reference to specific forms) Expanded to better reflect process for workplace safety hazards.