Reporting, learning from and reducing adverse events and potential patient harm is part of fostering safe systems of care and risk management. Factors that may contribute to adverse events could include: organizational processes, knowledge deficits, staffing, communication breakdown, or human factors.

This risk profile includes a variety of different types of adverse events that are identified by some organizations in the Risk Register application in a general category instead of using specific types of adverse events. Some examples may be related to triage/assessment, recognition of changing patient status, medication errors, wounds, crisis response, emergency codes, allergic reactions/anaphylaxis, equipment failures, accidental burns and general avoidable harm to patients. Specific information related to medication adverse events or falls is available in the topic-specific risk profile. This document contains information entered by your peers in the Risk Register application to help you manage this risk.

**Ranking/ratings:**
- Likelihood – average score 3.10
- Impact – average score 3.81

The Risk Register allows for risks to be assessed on a five-point likelihood and impact scale, with five being the highest.

**Key controls/mitigation strategies**

- Integrated approach
  - Risk Management Program
  - Rapid escalation processes
  - Patient safety initiatives
    - Patient huddles, executive walk-abouts, medication reconciliation, and patient safety culture plan
  - Patient and family engagement for quality improvement plans
  - Family perceptions for considering patient deterioration which could include changes in patient alertness, level of awareness, restlessness or agitation
  - Incident reporting systems and timely notification and communication of adverse events
  - Transfer of accountability/handoff tools and processes
  - Staffing skill mix assignment
  - Clinical rounding
  - Diabetic consultation service to escalate urgent situations and potentially averting ER visit
  - Case Reviews, incident debriefs, and/or root cause analysis

- Policies/procedures/processes
  - Clinical practice guidelines and best practices from organizations developing standards, for example: regulated colleges or associations, Accreditation Canada, infection control organizations, organizations for health quality
  - Prevention and treatment of IV extravasation, safe storage of medications
  - Prevention of entrapment and strangulations
  - Prevention and management of latex allergies
  - Independent double checks of high-risk medications
  - Electronic Medical Record Adoption Model (EMRAM)
  - Managing Obstetrical Risk Efficiently (MORE™)
  - Standard operating procedures
    - crisis response
    - risk assessments and timelines for at risk patients who are suicidal, self –injurious or show aggressive behaviours

- Allergies
  - Electronic Health Record (EHR) allergy field not remaining blank and either complete no known allergy or the allergy identified with the field. EHR as single source allergy identification versus various documents
Care – Adverse events (general)

- Anaphylaxis kit available on resuscitation cart on unit. Anaphylaxis kit programed as function in the automated drug dispensing cabinets
- Single patient ID band that is colour coded if patient has allergies
- ID band and allergy checks as mandatory elements of the nursing shift handover safety checks
- Medication not provided until history of allergies known and documented

- Paediatric
  - Expressed Breast Milk (EBM)
    - Collecting, processing and feeding of EBM using independent double checks
    - Release of EBM specific form upon discharge and barcode scanning
  - Comprehensive newborn discharge summary is provided for all families at discharge, detailing their in-patient admission and follow up appointments/clinical care
  - Emergency Codes-Code Pink Cardiac Arrest/Medical Emergency – Infant/Child
    - Paediatric resuscitation carts standardized across organization
    - Paediatric Advanced Life Support (PALS) certification
    - Standardized code record and code cart checklist

- Equipment
  - Equipment centralized with preventative maintenance program in place (e.g. IV pumps)
  - Magnetic Resonance Imaging (MRI) safety labels of all equipment with MRI safe, MRI conditional to a certain distance and MRI not safe label. Key pad access to MRI environment
  - Closed-loop medication management systems (including barcode packaging)
  - Compliance with Canadian Standards Association standards for medical gas delivery systems and inhalation anesthesia

- Education and training
  - Family education materials prominent in clinical areas
  - Training on guidelines, procedures or policies (e.g. entrapment prevention)
  - Clinical teaching and coaching related to IV injury prevention
  - Training in CPR, SBAR
  - Skills drill code responses
  - Communication escalation protocol
  - Extubating readiness, sedation practices and timing
  - Standardized use of insulin pens and education to prevent errors
  - Sticker on badge identifying level of MRI training and additional annual education depending on level
  - Non-violent crisis intervention training within higher risk clinical areas

Monitoring/indicators

- Patient safety incident (and near miss) trending shared at quality committees and across organization
- Patient/family complaint tracking
- Numeric count of feedback/themes from daily or scheduled huddles
- Human resource indicators related to increase in absenteeism, transfers and resignations
- Staff engagement in patient rounds
- Allergic reactions monitored daily
- Compliance audits e.g. policies, mandatory education, documentation-allergy field completion, code cart checklist/stocking
- IV injury assessment tool to track and monitor severity of IV relate injuries
- Number of unplanned loss of endotracheal tube per 100 intubated days
- Patient safety culture survey
- Workplace violence incident report tracking