



BC Patient Safety  
& Quality Council

## Patient Safety Event Reporting Working Group

Update for the Health Quality Network, Nov 25, 2009

Georgene Miller, Chair

## Two Aims:

- Develop core elements to be reported to Health Authority Boards and Senior Leadership Teams.
- Develop a template for patient safety event learning summaries along with a process for sharing and dissemination across the province.



Develop a template for patient safety event learning summaries along with a process for sharing and dissemination across the province.

- Decision: explore use of sending out provincially – distributed by BCPSQC
- Next steps:
  - Build template with input from all health authorities and other service partners
  - Develop criteria to identify when there would be value in provincial distribution
  - Understanding of alert vs. learning summary (when to use)



## Develop core elements to be reported to Health Authority Boards and Senior Leadership Teams

Have surveyed all Health Authorities to review what is currently being done:

- All HA's report information on safety events to Quality Committee of Board
- Common review techniques – mostly based in Root Cause Analysis
- variation in the process of initiating investigation and reporting format
- some HA's are in process of revising policies and formats – good timing for the work of this group



## Develop core elements to be reported to Health Authority Boards and Senior Leadership Teams

### Next steps:

- Fill in some information gaps on current policies and report formats
- Identify and share best practices (from BC and external literature)
- Potential opportunity to inform Boards/Quality Committees on use of the information at a strategic level
- Potential opportunity to get input from Boards/Quality Committees on information that is valuable to them