First Nations Health Authority
Health through wellness

HAÍŁCÍSTA

"to take a turn for the better"

Nursing Quality Reporting System

HAÍŁCÍSTA Training

September 15, 2020

By the end of the learning session you will be able to:

- Describe the importance of a patient safety culture and how HAÍŁCÍSTA supports this
- Demonstrate an understanding of how to categorize incidents
- Describe the process after a report is submitted
- Submit incident reports as part of your practice

Why report incidents?

Reporting incidents is about discovery, supporting learning addressing system issues and 'taking a turn for the better.'

FNHA Directives:

Directive #3 – Improving services
Directive #7 – Function at a high operational standard: Be accountable through clear, regular & transparent reporting

Why report incidents?

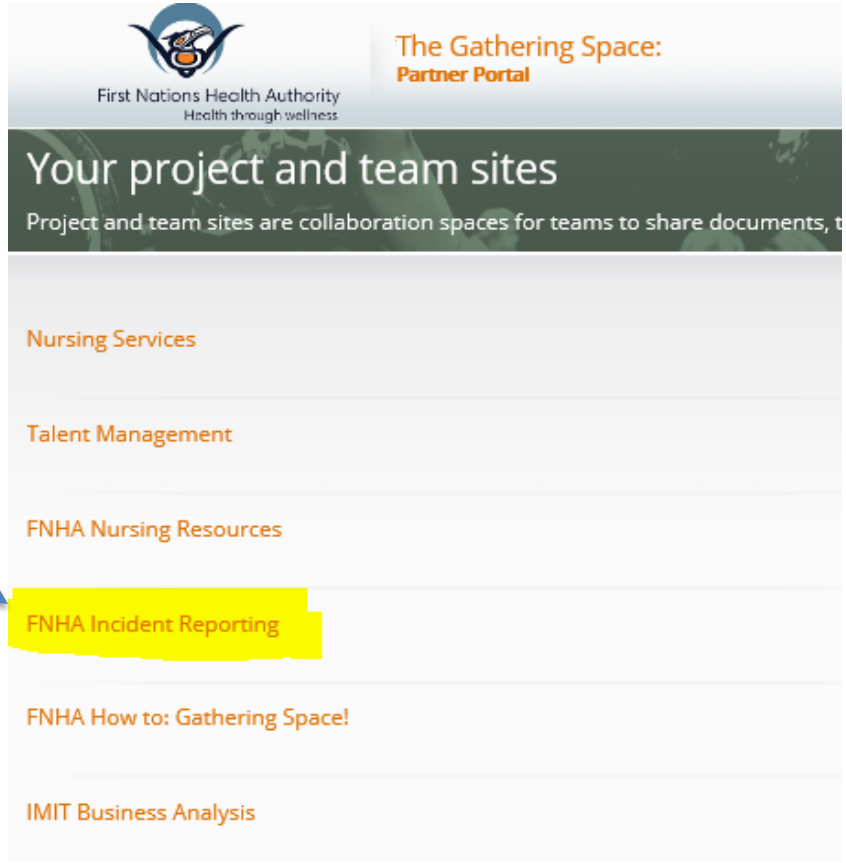
We are all responsible for safe and high quality care!

Helps us take a systems instead of individual view of the issues we face, since majority of incidents involve at least one systems issue.

Helps us learn to improve everyday practice!

FNHA's Incident Reporting System for Clinical Events is called HAÍŁCÍSTA

- Gathering Space homepage, click on FNHA Incident Reporting



What does HAÍŁCÍSTA mean?

HAÍŁCÍSTA
haith-see-sta
'to take a turn for the better'

'HAÍŁCÍSTA' is from the Heiltsuk peoples, it comes from the word for reconciliation, Haíłcístut. We thank the Heiltsuk people for this beautiful meaning as it captures the direction of FNHA Nursing Services incident management system.

When naming the system in 2019, we asked for suggestion from nurses. They asked for a positive term to reflect that we are committed to safety, improving care and learning, rather than the usual 'incident management'.

Thus, we are fortunate for the name HAÍŁCÍSTA because **we want to take a turn for the better** in all we do.

Watch the video "Annie's Story: How A System's Approach Can Change Safety Culture"

- https://www.youtube.com/watch?v=zeldVu-3DpM

If you were Annie's colleague, how would you react to her after this event?

How would you feel if you were Annie? After you were disciplined? After you returned to work?

How do we change for the better?

FNHA Clinical Nursing Services takes a non-punitive, non-blame approach to tracking and analyzing incidents while ensuring accountability.

This supports a patient safety culture.

A PATIENT SAFETY CULTURE is: CPSI 2019

Informed culture	**relevant safety information** is collected, analyzed and actively disseminated
Learning culture	preventable events are **opportunities for learning** and changes are made
Just culture	**fairly balancing** an understanding system failure with professional accountability
Flexible culture	capable of **adapting effectively** to changing demands
Reporting culture	people have the confidence and **feel safe to report** safety concerns without fear of blame, and they trust that concerns will be acted upon

Part of a safe reporting culture is supporting each other when an incident happens

The Second Victim

The healthcare professionals who are involved in the incident, the so-called second victims, can also experience distress, such as guilt, anger, frustration, psychological stress, and fear, as well as physical symptoms such as fatigue, insomnia, and aberrant behaviors

”The most important factor is to listen and acknowledge their feelings and what they are experiencing.”

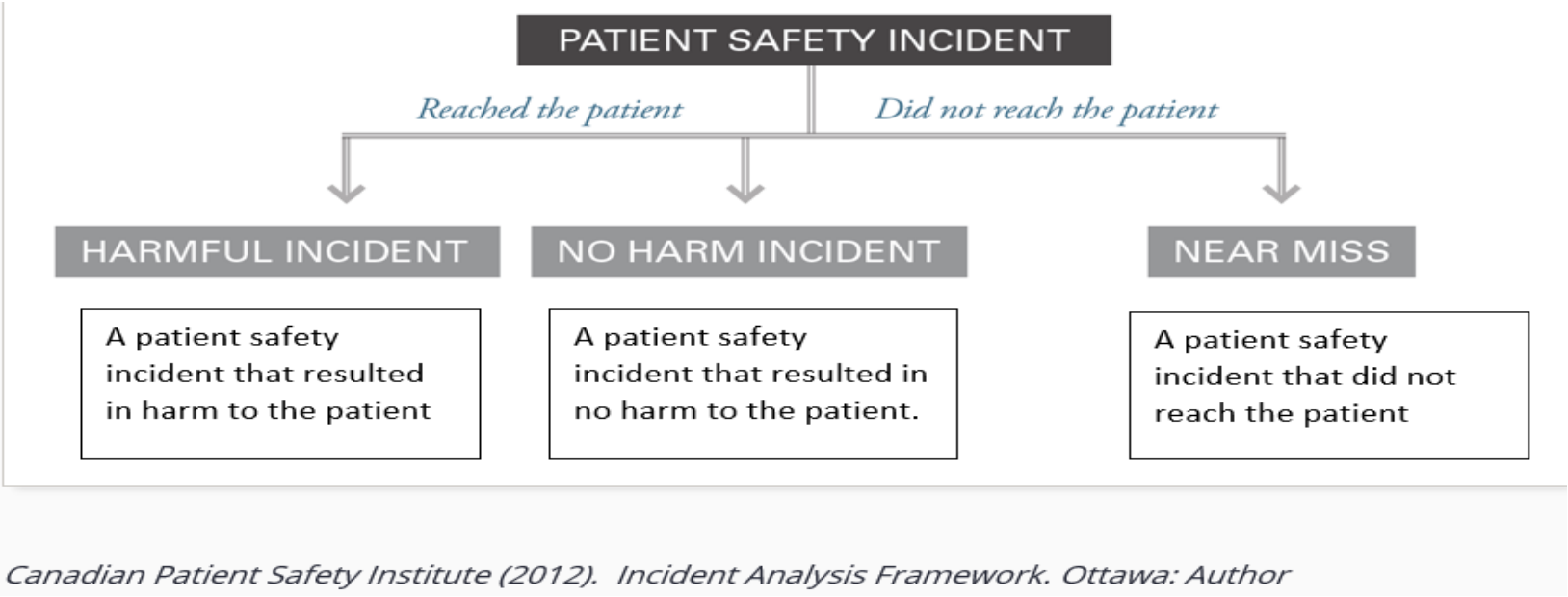
Liliane Prairie, National Coordinator, OCISM

Sorry this happened to you.

Do you want to talk about it?

What should be reported?

Any incident that has the potential to cause staff or client harm, **including a close call or near miss**



Canadian Patient Safety Institute (2012). Incident Analysis Framework. Ottawa: Author

If the incident involves staff safety, mandatory legal reporting, worker safety or immunization adverse events, additional reports will be required

A word about near misses

"A **near miss** in medicine is an event that might have resulted in harm but the problem **did not reach the patient** because of timely intervention by healthcare providers or the patient or family, or due to good fortune."
Canadian Medical Protective Association, 2019

History has shown repeatedly that most catastrophic incidents are preceded by warnings or near miss incidents.

National Safety Council, 2014

What if the system is down?

- Use paper forms

- Once the system up and running, also document in the online system

What will happen when you report an incident?

- Report as soon as possible after the event (service standard = no later than **48 hours post-incident**)

- Takes about **5 minutes** to complete the report

- Automatically sent to operations managers, quality manager & professional practice lead. If an immunization incident, also to the immunization team

- More critical events escalated to nursing directors/CNO

What happens when you report an incident?

- All events reviewed, follow-up/support given prn, documented into the system and reported back to point of care nurse. (Service standard – manager report back to the nurse as soon as possible after report submitted, but not more than 48 hours after report submitted and then ongoing as needed)

- **For critical events continue to notify your Leader on Call or manager immediately e.g. via phone**

How will reports be used?

- Individual reports – follow up with managers/prof practice lead. Operations manager is handler

- Regular analysis of aggregate data – can report to individual nursing stations and roll-up for a more complete picture

- Critical incidents - develop a process of team analysis & recommendations

- **Ultimately, the information will be used to improve safety and quality**

Who has access to system?

- Front end – All FNHA nurses, Agency nurses

- Backend – operations manager, quality manager, professional practice lead, operations director, collaborative practice director, chief nursing officer. Immunization team for immunization incidents

What do you think are some of the benefits of a reporting and management system for clients & community, staff and the FNHA organization?

Think of one benefit for each before seeing answers on next slide.

Benefits of HAÍŁCÍSTA

Clients

- Faster follow-up for clients / community because of easier reporting by staff
- Addition of disclosure field means increased accountability for disclosure and client/family engagement

Staff

- Clearly outlines reporting expectations
- Decreased delays in notifying manager
- Electronic feedback to reporter, closing loop
- Ability to escalate incidents
- Enhanced team approach to managing incidents
- Focus on safe/just culture, learning and improving
- Better ability to address systems issues

Organization

- Better data and measurement to support systems issues
- Transparency, accountability, and commitment to patient and staff safety
- Improved service delivery

Next: Click on the **video demonstration** on Learning Space to see how to submit a report.

After: Complete the quiz.