# NWT Critical Incident Reporting Guidelines 2020

**Government of the Northwest Territories**
Department of Health and Social Services

## Contents

## Introduction

The Department of Health and Social Services (DHSS) developed these Guidelines, in alignment with the *Hospital Insurance and Health and Social Services Administration Act* (***HIHSSA***[1]) *Critical Incident Reporting and Investigation Regulations*, to provide recommendations, for **staff** and administrators working within the Northwest Territories (NWT) health and social services system. These Guidelines are used to determine whether a **patient safety incident** would qualify as a '**Critical Incident**' or an alleged **critical incident** and the required steps to respond, notify, investigate, and submit a report in accordance with ***HIHSSA*** legislation and regulations.

When a **patient safety incident** occurs within the NWT health and social services system it is essential to have an environment that promotes reporting and open participation in the **investigation** by all **staff**. To facilitate this, parts of the investigation process, including perceptions, information and findings are confidential and privileged under the law. Only the recommendations are made public. The intent is to encourage and support **staff** to speak honestly and openly about what occurred in order to make improvements in the system.

An effective, collaborative, compassionate and system approach is required to ensure adherence to applicable legislation and regulations. To provide some context of our system, NWT health and social services authorities ('**Authorities**') are required to lead their own regular internal **audit** process and establish **Quality Assurance Committees**, in accordance with ***HIHSSA***, as a means to responding to issues that are detected in their regular **audits** or are non-critical in nature. The DHSS is responsible for conducting routine and ad-hoc **inspections** to ensure adherence to program and service delivery standards (Ad-hoc **inspections** can also arise when there is a specific case or **audit**(s) that require a full review as provided for in ***HIHSSA***). These comprehensive reviews are conducted by individuals with statutory appointments of '**Inspector and Auditor'** status. Statutory appointments are required to enable access to records, charts, and private health information etc. However, if an incident is determined to be a **critical incident** or an alleged **critical incident** it is essential that the **Authorities** notify the Minister, and work collaboratively with the DHSS in order to conduct an **investigation** to actively respond to the situation and to improve upon and provide safe, quality and effective care.

The reporting of any **critical incidents** or an alleged **critical incident** is crucial to transparency, accountability and to quality assurance processes for the health and social services system. Reporting and **investigations** of **safety incidents** reflects a continual commitment to improvement and learning with the purpose, not assigning blame but rather to offer an opportunity to improve care and **patient/client** outcomes while respecting privacy.

Information from the Canadian Patient Safety Institute, Manitoba's *Regional Health Authorities Act* and Manitoba's *Critical Incident Reporting Guidelines*, Saskatchewan's *Critical Incident Regulations,*

[1] Words or phrases in **bold** print are found in the Definitions.

*2016* and the *Saskatchewan Critical Incident Reporting Guideline, 2004* and the Nunavut Policies on Client and Staff Safety Events have been used to develop these guidelines.

## Glossary of Terms

**Audits**: Assessment of overall compliance with one or more standards, policies, procedures, programs, and applicable regulations/legislation conducted regularly by **Authority staff** (e.g. Community Health Nurses, Nurse-in-charge, Managers etc.). **Audits** and **audit** records may be accessed directly as necessary by a statutorily appointed **Auditor**, and the Department can request information on the analysis and trends noted in the **audits** to monitor, measure, and evaluate quality.

**Authorities**: All NWT Health and Social Service Authorities ('**Authorities**'): Northwest Territories Health and Social Services Authority (NTHSSA), Hay River Health and Social Services Authority (HRHSSA), and the Tłı̨chǫ Community Services Agency (TCSA).

**Chair**: The individual responsible for notifying the Minister of an alleged **critical incident** and the individual accountable for appointing a **Critical Incident Investigation** (i.e. the **Chair** of the NTHSSA Leadership Council, the **Chair** of the TCSA (Board of Management), or the **Chair** or Public Administrator of the HRHSSA (Board of Management)).

**Critical Incident**: as defined in HIHSSA is an unintended event that occurs when health services or social services provided to a **patient** or client result in a consequence to him or her that

a) is serious or undesired, such as:
    i. death, disability, injury, or **harm**,
    ii. an unplanned admission to a health facility or an unusual extension of a stay in a health facility, or
    iii. a significant risk of substantial or serious **harm** to the safety, well-being or health of the patient or client, and
b) does not result from an underlying health condition of a **patient** or client or from a risk inherent in providing the health services or social services to him or her.

**Disclosure**: The process by which a **safety incident** is communicated with the **patient/client** and/or **family** by **staff** (e.g. Chief Operating Officer (COO)/Chief Executive Officer (CEO) or designated care provider). This is a multistep process that begins with acknowledgement, apology, and an offer to share known facts and next steps about the incident.

**Family**: A person(s) whom the **patient/client** wishes to be involved in their care, and who may act on behalf of and in the interest of the **patient/client**. This could be a **family** member or close friend that is listed as an emergency contact, or a guardian, or a support person, or a legally appointed substitute decision maker.

**Harm**: Impairment of structure or function of the body or mental health and/or any deleterious effect arising therefrom. **Harm** includes disease, injury, suffering, disability and death.

**HIHSSA**: means the *Hospital Insurance and Health and Social Services Administration Act,* R.S.N.W.T. 1988 as amended.

**Inspections**: Structured process of collecting independent information on the efficiency, effectiveness and reliability of systems or services and making recommendations to correct or improve deficiencies. They are conducted regularly, or as necessary, by statutorily appointed **Inspectors**.

**Inspectors and Auditors**: Statutorily appointed person(s) under section 25.7 of ***HIHSSA*** to conduct **inspections** and **audits** in the NWT health and social services system.

**Investigation**: A comprehensive analysis of a **critical incident** or an alleged **critical incident** as defined by ***HIHSSA*** by a person or committee appointed as **Investigators** by the relevant body. The **investigation** includes but is not limited to medical records, audits, and interviews with a purpose to:

a. Review whether or not a **critical incident** occurred;
b. Review factors that may have caused or contributed to a **critical incident**; and
c. Prevent the occurrence of **critical incidents** in the future.

**Investigator**: Statutorily appointed person(s) or a committee appointed or assigned under subsection 25.3 (2) or (3) of ***HIHSSA*** to investigate a **critical incident**.

**Patient/Client**: A person who is receiving, has received, or has requested care within the health and social services system. This term is inclusive of residents and outpatients.

**Safety Incident**[2]: The Canadian Patient Safety Institute defines this as an event or circumstance which could have resulted, or did result, in unnecessary **harm** to a **patient/client**. There are three types of **safety incidents** that can affect a **patient/client**:

- No-**harm** incident: A **safety incident** that reached the **patient/client** but no discernible **harm** resulted."
- Near miss: A **safety incident** that did not reach the **patient/client** and therefore no **harm** resulted.
- Harmful incident**:** A **safety incident** that resulted in **harm** to the **patient/client**. Replaces "preventable adverse event"

**Quality Assurance Committee**: established under the ***HIHSSA*** (section 25.1) on direction from the Minister, NTHSSA Leadership Council, or Board of Management responsible for the organization. The purpose is to conduct planned or systematic activities for the purpose of studying, reviewing, investigating, assessing or evaluating the provision of health services or social services, either ongoing or case specific, and with a view to improve :

(a) the provision of health services and other services in the territorial health system;
(b) medical or hospital care;
(c) medical research;
(d) the provision of social services;
(e) care in social services institutions; or

[2] Adapted from the Canadian Patient Safety Institute, Patient Safety Incident (2016).

any program carried on in respect of health services or social services. Activities of the **Quality Assurance Committee** are protected under the *Evidence Act,* R.S.N.W.T 1988, which means that records or information gathered during the quality assurance activity is strictly limited.

Examples of Quality Assurance Committees' are the Maternal Perinatal Committee and the Morbidity and Mortality Committee.

**Quality Risk Manager (QRM)**: Qualified **staff** within the **Authorities** who identify and evaluate potentials risks in order to reduce **harm** to **patients/clients**, **staff** members, and visitors within an organization to make changes to improve individual outcomes and enhance system performance. This work is completed both proactively and reactively and considers the quality of care, and the individual's safety, quality and rights in all aspects.

**Staff**: All employees of the NTHSSA, HRHSSA, and the TCSA.

**Supervisor:** Person to whom **staff** members report to directly, and who monitors and regulates employees in their performance of assigned or delegated tasks. This includes but is not limited to: Managers, Clinical Coordinators, Nurse-In-Charge, Patient Care Coordinators, Medical Directors, or **Supervisors**.

## Safety Incident Review Process

## Safety Incident Guidelines

This Guideline recommends the steps that should be taken in any **safety incident** but actual steps must reflect the needs of the individual situation. The purpose is to determine whether or not an incident requires **critical incident** notification and **investigation** (See Appendix A). Individuals should make all reasonable effort to meet the timelines outlined below.

### *Authorities' Roles & Responsibilities (Within 1 business day)*

1. **Staff** member encounters, witnesses or becomes aware of a potential incident occurring.
2. Take immediate action, dependent on the type of incident that occurred, to ensure the health and safety of **patient's)/client's),** visitors, and **staff** and if possible prevent the incident from reoccurring. The most appropriate **staff** member should complete this with assistance of the **supervisor** as necessary.
3. Respond to and support **patient's/client's** immediate emotional and physical needs; document in their health care record, counselling record and/or child and family service record, as required.
4. Respond to and support **staff's** immediate emotional and physical needs, as required.
5. Incident reported by **staff** member to **supervisor;** can initially be oral, but must be followed in writing, through the electronic incident reporting system, or according to regional policy (e.g. Risk Monitor Pro, RL6 etc.).
6. **Supervisor** arranges for coverage of duties; facilitates access to counselling and debriefing as required.
7. Contact RCMP, Coroner, Chief Public Health Officer, and/or social services as necessary.
8. Secure the health record, counselling record and/or child and family service record in a restricted area, according to **Authority** policy.
9. Preserve evidence as required (e.g. take photos, removal of equipment, products, medications as required, retrieve data from equipment prior to repair etc.).
10. **Supervisor** notifies **QRM**. This may be automatically done by the electronic incident reporting system.
11. **QRM** notifies COO/CEO of incident, of the immediate actions that have occurred and that a formal initial review will take place. COO advises CEO who may wish to alert the Deputy Minister per judgment based on initial knowledge of severity of the incident.

### *Authorities' Roles & Responsibilities (Within 3 business days)*

12. CEO/COO involves legal counsel/ labour relations/Workers Safety and Compensation Commission (WSCC), RCMP, and/or coroner, as indicated by type of incident.
13. **QRM** or designate confirms relevant physical, material, and documentary evidence (e.g. charting) related to incident is acquired and ensures it is secured and preserved for review.
14. **QRM** or designate identifies anyone who may have been involved, including witnesses, and ensures that any physical or emotional supports for **patients/clients** or **staff** have been facilitated.

15. COO/CEO or designate ensures that arrangements are made for discussion with the **patient/client** and/or **family** and determines who will be the point of contact from the organization.
16. COO/CEO identifies the most appropriately suited lead from the **Authority**, to conduct initial internal Summary of Findings (e.g. **Supervisor** for specific area, or **QRM**) for the purpose of:
    a. gathering facts and developing a confidential Summary of Findings Report (Appendix B) that is provided to the COO/CEO.
    b. determining whether or not the event meets the definition of a **critical incident** or an alleged **critical incident** or requires another type of examination (e.g. **quality assurance review**).
17. The lead prepares and provides the written Summary of Findings Report (see Appendix B) to COO/CEO and proposes further plans for **investigation** depending on the Decision Pathway for Critical Incidents according to RL6 (Appendix A).
18. COO/CEO reviews Summary of Findings Report and determines if there is a need for **critical incident** notification.
19. Upon determination of an alleged **critical incident:**
    a) COO/CEO advises **Chair** of the applicable Leadership Council or Board of Management.
    b) Leadership Council or Board of Management notifies the Minister of the incident and provides the Summary of Findings Report, including any plans for **investigation** (See Appendix B). The Leadership Council or Board of Management may advise of their intent to appoint a person or committee to investigate the **critical incident**.
    c) COO/CEO ensures that arrangements are made to conduct an initial **disclosure** meeting with the **patient/client** and/or **family** to notify of incident, express apology, discuss next steps identified, and plan for follow-up. Seek guidance from legal counsel, if required. Arrange to have immediate counselling support available for all involved, if required.
    d) COO/CEO shall appoint a lead media spokesperson identified as necessary with development of key messaging.

### *Department of Health and Social Services Roles & Responsibilities*

Upon notification of an alleged **Critical Incident**, the Deputy Minister initiates the Department's Internal Review process bringing together an ad-hoc Incident Review Committee:

1. Deputy Minister reviews Summary of Findings Report, including plans to investigate. May seek outside advice from Legal Counsel or Risk Management.
2. Incident Review Committee ('Committee') convened. Depending on the nature of the incident, Deputy Minister requests representation from areas of practice within department (e.g. nursing, public health, rehabilitation services, mental health, child and family services, etc.).

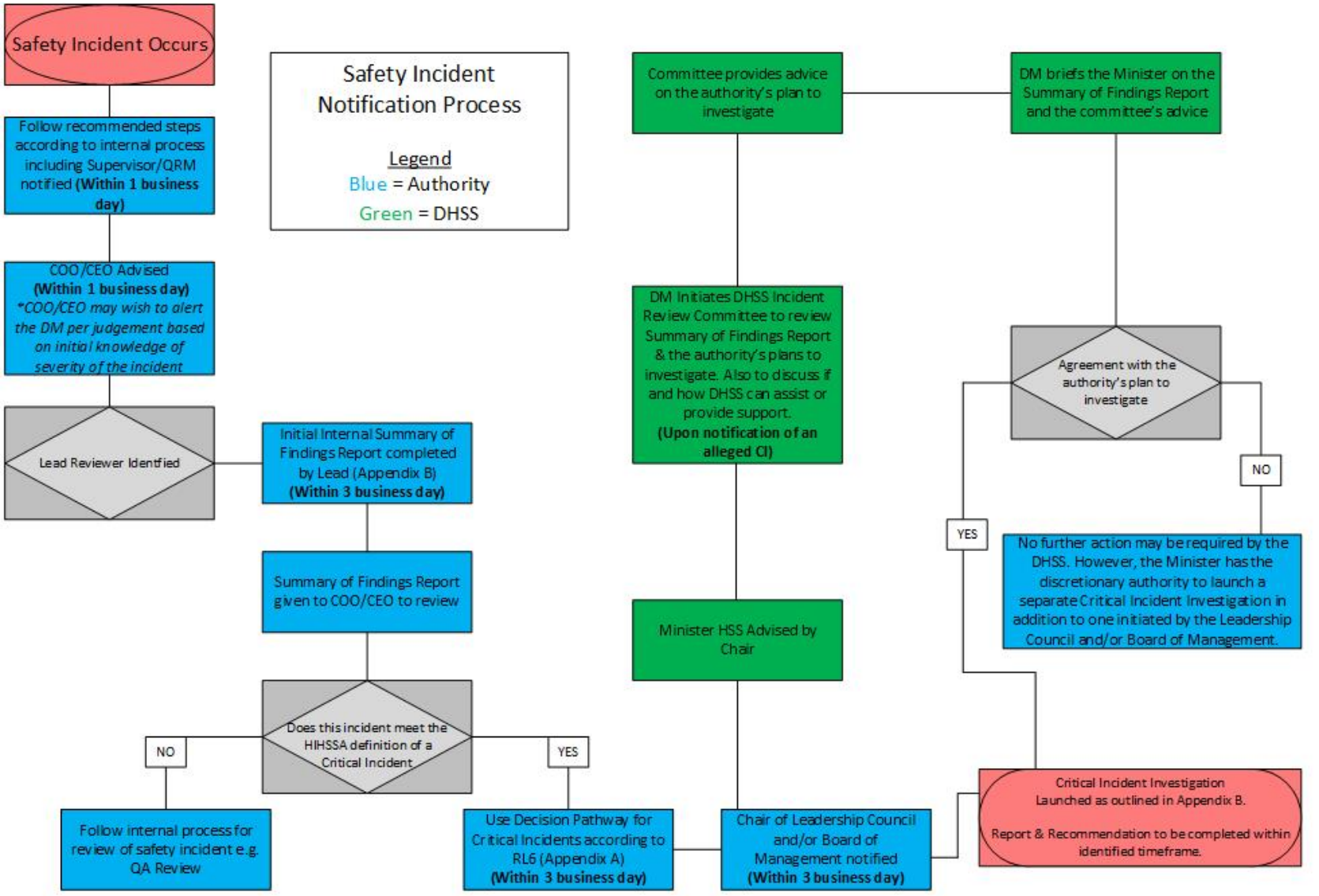
3. Committee reviews the Summary of Findings Report prepared by the **Authority** on their initial review and provides feedback to the Deputy Minister.
4. Consultation may be necessary from Legal Counsel, Department of Finance: Risk Management and Insurance and/or Human Resources.
5. Deputy Minister briefs the Minister on the Summary of Findings Report. Feedback from the Committee's review of report will also be presented on the **Authority's** plan to investigate.

*As required, the DHSS may also be requested to provide support and assistance to the Authority for a critical incident investigation. For example:*

- *DHSS staff to investigate and/or provide assistance to investigators.*
- *Provide sample templates such as Terms of Reference, Notification Letters, Appointment letters etc.*
- *Assist with critical incident investigation process.*
- *Provide contact information for a third party confidential transcriptionist*

6. No further action may be required from the Department while the **Authority** conducts the investigation, however, the Minister has the discretionary authority to launch a separate Critical Incident Investigation process in addition to one initiated by the Leadership Council and/or Board of Management.

## Safety Incident Notification Process




*Note: CFS service incidents are to follow the process outlined in the Child and Family Services Act*

## Critical Incident Investigations Overview

**Critical incident investigations** can be initiated by the **Authority** (from the Leadership Council or the Board of Management), the Minister, or by a motion in the Legislative Assembly. As outlined in section 25.3 (1) in ***HIHSSA***, there is a requirement for the **chair** to notify the Minister of any **critical incident** that occurs or **critical incident** alleged to have occurred.

Note that the Safety Incident Review Process (page 6) determines whether or not an incident requires critical incident notification and investigation. At the time of a Critical Incident Investigations Overview, an investigator(s) will complete a **critical incident investigation**. The purpose of a **critical incident investigation** is to:

a. Review whether or not a **critical incident** occurred;
b. Review factors that may have caused or contributed to a **critical incident**; and
c. Prevent the occurrence of **critical incidents** in the future.

Once it is determined that a **critical incident investigation** is required the next steps are as follows:

1. Appointment of an **Investigator** or committee by **Authority** (i.e. **Chair** of Leadership Council or Board of Management), or Minister, or Deputy Minister.
2. Review and establishment of methodology (see section below).
3. **Critical Incident investigation** conducted according to methodology (this can be accomplished by using internal existing resources or hired externally). The **investigation** may or may not include DHSS staff.
4. External liaison and media communication determined and coordinated with the **Authority**.
5. Confidential report provided to Minister and appointing body.
6. Separate appendix of recommendations (to be made public) provided to Minister and appointing body.
7. Recommendations examined and action plan is determined including measures for follow up and monitoring.
8. Communications plan applied, for public, **staff**, and to **patient/client/family.**

## Department of Health and Social Services Roles & Responsibilities

Upon notification of an alleged Critical Incident, the Deputy Minister initiates the Department's Internal Review process bringing together an ad-hoc Incident Review Committee:

1. Deputy Minister reviews Summary of Findings Report, including plans to investigate. May seek outside advice from Legal Counsel or Risk Management.
2. Incident Review Committee ('Committee') convened. Depending on the nature of the incident, Deputy Minister requests representation from areas of practice within department (e.g. nursing, public health, rehabilitation services, etc.).
3. Committee reviews the Summary of Findings Report prepared by the Authority on their initial review and provides feedback to the Deputy Minister.

4. Consultation may be necessary from Legal Counsel, Department of Finance: Risk Management and Insurance and/or Human Resources.
5. Deputy Minister briefs the Minister on the Summary of Findings Report. Feedback from the Committee's review of report will also be presented on the Authority's plan to investigate.
6. No further action may be required from the Department while the Authority conducts the investigation, however, the Minister has the discretionary authority to launch a separate Critical Incident Investigation process in addition to one initiated by the Leadership Council and/or Board of Management.

## Critical Incident Definition and Examples[3]

A **critical incident** refers to an unintended event that occurs when health services or social services provided to a **patient/client** result in a consequence to them that:

a) Is serious or undesired, such as:
   i. Death, disability, injury, or **harm**,
   ii. An unplanned admission to a health facility or an unusual extension of a stay in a health facility, or
   iii. A significant risk of substantial or serious **harm** to the safety, well-being or health of the **patient/client**, and
b) Does not result from an underlying health condition of an individual from a risk inherent in providing the health or social services to them.

**The following examples of events may be reportable to the Minister of Health and Social Services as critical incidents. An event that matches an example below still needs to be examined against the HIHSSA critical incident definition (e.g. was there an underlying health condition that contributed to the event). These do not replace the above definition, nor are they intended to be inclusive of only those events that meet the definition of critical incident.**

If a **safety incident** occurs that results in no-harm or is a near-miss, it does not meet the *HIHSSA* definition of **critical incident**. These situations however should be managed by the Authority involved through their internal processes (i.e. Quality Assurance Review Process), to determine recommendations and steps to prevent reoccurrence. Even if the **safety incident** does not meet the definition of a **critical incident**, it still may provide a learning opportunity to improve services.

### *Clinical Care Management*

- Death or serious disability associated with a medication or fluid administration error including, but not limited to, errors involving the wrong drug, the wrong dose, the wrong

[3] Adapted from Government of Saskatchewan, *The Critical Incident Regulations* (2016), and Government of Manitoba, *The Regional Health Authorities Act,* C.C.S.M c. R34.

person, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration
- Death associated with a hemolytic reaction due to the administration of ABO incompatible blood or blood products
- Death associated with severe hypoglycemia, the onset of which occurs while in the care of the organization/facility
- Error in diagnosis, where the treatment provided or not provided, is associated with death or serious disability
- Death or serious injury associated with a delay or failure to transfer a critically ill individual to more appropriate care delivery facilities
- Stage 3 or 4 pressure ulcers acquired after admission to a health care facility
- Full term fetal or neonatal death or serious disability associated with labor and delivery while being cared for in the organization/facility
- Maternal death or serious disability while being cared for in the organization/facility
- Death associated with a hospital acquired infection
- A **safety incident** leading to death or serious disability associated with any other clinical care management event while an individual is receiving a health care or social service provided by an organization/facility

### *Surgical (including endoscopies and other invasive procedures)*

- Surgeries performed on a wrong body part
- Surgeries performed on the wrong individual
- The wrong surgical procedure performed on an individual
- Retention of a foreign body in an individual after surgery or procedure
- Death during or immediately following surgery in an individual with a low anaesthetic risk score
- Unintentional awareness during surgery with recall by the individual
- A **safety incident** leading to death or serious disability associated with surgery

### *Environmental*

- Death or harm of a child/youth in foster care or residing in an out of territory treatment or care facility
- Death or harm of a mental health or addictions client while in a territory facility or an out of territory treatment or care facility.
- Death or serious disability associated with electric shock while being cared for in the organization/facility
- Death or serious disability associated with a burn incurred from any source while being cared for in the organization/facility
- Death or serious disability associated with the use or lack of restraints or bedrails while being cared for in a facility
- Death or serious disability associated with a fall while being cared for in the organization or facility
- Death or serious disability associated with the failure or de-activation of exit alarms or environmental monitoring devices
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
- Death or serious disability incurred as a result of transport arranged or provided by the organization/facility

- Death or serious disability associated with a delay or failure to reach a patient for emergent or scheduled services provided by the organization/facility
- A **safety incident** leading to death or serious disability associated with any other environmental event while an individual is receiving a health care or social service provided by an organization/facility

### *Patient/Client Protection*

- An infant discharged to the wrong person(s)
- Death or serious disability associated with an individual's disappearance
- Suicide or attempted suicide, while under care of an organization/facility, including events that result from an individual's actions after admission to a facility or program of the health care organization
- A **safety incident** leading to death or serious disability associated with the delivery of health care or social service

### *Equipment or Devices:*

- Death or serious injury associated with improper use of an on-site naloxone kit
- Death or serious injury associated with use of contaminated drugs, devices and biologics or the use/function of a device when the device functions other than intended
- A **safety incident** leading to death or serious disability associated with any other product, equipment or device while a **patient/client** is receiving a health care or social service provided by an organization or facility

### *Criminal Events*

- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, mental health practitioner, social worker, counsellor, or other licensed health care provider
- Abduction of a **patient/client** of any age
- Sexual assault that occurs within a NWT Health and Social Services facility or controlled by the organization/facility
- Death or serious disability from a physical assault that occurs within a Health and Social Services facility or controlled by the organization/facility
- Any sexual or physical assault of a **patient/client** perpetrated by an employee or an individual under contract with organization/facility (including assaults perpetrated at a **patient's/client's** home while receiving home care or mental health/ social services support)
- A **safety incident** leading to death or serious disability associated with any other criminal event while an individual is receiving a health care or social service provided by an organization/facility

## Critical Incident Investigation Methodology

The circumstances around every incident will differ and the scope of the investigation will vary, therefore the methodology for completing the investigation will be determined by the identified lead investigator and the person designated by the appointing body. Although the approach will vary dependent on the incident, there are certain overarching steps that need to be completed for EVERY **critical incident investigation** or elements that should be considered:

1. **Investigation Terms of Reference (TOR)**: developed by the lead agency investigating (i.e. **Authority** or DHSS). See Appendix C for sample template.
    a. Methodology outlined in the **Investigation** TOR.
    b. Read and signed by both the **Investigator** and appointing body.
2. **Consultation**: Consultation will need to be undertaken by the lead agency investigating depending on the incident.
    a. Legal counsel is required for every **critical incident** (e.g. legal to review TOR, and notification letters for **patient/client, family** and staff).
    b. Risk Management
    c. Human Resources or Labour Relations.
3. **Investigator(s)**: Selected and appointed as provided for in ***HIHSSA*** by the lead agency investigating.
    a. Require a notice of appointment of '**investigator** status' with a copy provided to **investigator** before they commence **investigation**.
    b. Contract developed and signed by **investigator** (if hiring an external investigator).
    c. **Investigation** TOR, including methodology, signed by **investigator** and appointing body (i.e. **Chair** or Minister).
4. **Communication with family:** After initial **disclosure**, CEO/COO needs to make **patient/client** and/or **family** aware of the fact that a **critical incident investigation** will be undertaken.
    a. Notification letters sent to family (See Appendix D).
    b. Must determine who will be identified for ongoing communication with the **patient/client** and/or **family** (e.g. CEO, COO, Investigator, DHSS representative, or another member of the Committee).
5. **Formal communication with staff:** about **investigation** by the CEO/COO.
    a. Notification letters sent to staff about **investigation** process (See Appendix D).
6. **Investigation:** Methodology will differ depending on the incident but may include:
    a. Tour of space(s) where alleged incident occurred.
    b. Interview **patient**(s)/client(s), witnesses, **staff** involved in care, and **family**.
        i. Ensure up-to-date contact information (e.g. phone number and email).
    c. Review of evidence secured by the **Authority** (e.g. medical records and charting)
        i. Medical records, counselling records and CFS records are highly confidential. Secure transmission, context of use, and proper disposal needs to be upheld in accordance with the *HIA.*
    d. Logistics
        i. Identify liaison in community (ies) where incident occurred.

   ii. Secure private room to conduct interviews.
   iii. Arrange for refreshments for interviewees.
   iv. Audio recorder for taping of interviews as required by **investigator**. This may also be in the form of an official 'note taker'.
7. **Report**: Confidential document written by the **investigator** that is only permitted to be provided to specific person(s) according to **HIHSSA**. This report will include a conclusion that identifies whether or not a **critical incident** occurred.
8. **Recommendations**: Included as a separate appendix to the report, as only the recommendations may be made publicly available.

There may be times, depending on the complexity of the incident, which may require additional steps such as:

9. **Contract**: developed by the lead agency investigating (**Authority** or DHSS on behalf of the Minister) when an external **investigator** is hired to conduct investigation.
   a. Read and signed by the external **Investigator** who is hired for the purpose of the **Critical Incident investigation**.
   b. May contain appendices including a redacted TOR and budget allocation (DHSS has samples if required).
   c. Methodology is outlined in the **Investigation** TOR and in the contract for the external **investigator**.
10. **Media Communication**: Identified liaison by the lead agency investigating.
11. **Transcriptionist:** Recommended if audio recorder is used to tape the interviews.
   a. Consider conflict of interests and/or privacy concerns if using internal employee.
   b. DHSS has previously used a third party confidential transcriptionist and can provide support as necessary.
      i. Sole Source Authorization and contract, if applicable.

## Critical Incident Legislation

In accordance with ***HIHSSA*** and its' regulations, a person or committee appointed or assigned to conduct a **critical incident investigation** are:

1. Required to prepare a written report of the **critical incident investigation** and include any recommendations that the investigator considers appropriate.
2. Required to provide a copy of the **critical incident investigation** report to
    a. the person or body that appointed the **investigator** or assigned the **investigator** to the **investigation**; and
    b. the Minister.
3. Prohibited from sharing any information gathered, or record produced which include notes created or gathered during the **investigation**, by or for the **investigator** in the course of, or for the purpose of, the **investigation** to any person except:
    c. the Chair of the Leadership Council or Authority who has appointed or assigned the **investigator** to investigate the **critical incident**, or a person designated by the person or body;
    d. the CEO of the Authority in the case of an investigator if the investigator was appointed or assigned by the Leadership Council or Authority to investigate the **critical incident**;
    e. the Minister, in the case of an investigator appointed or assigned by the Chair of the Leadership Council or Authority to investigate the **critical incident**, or a person designated by the Minister;
    f. the DM, in the case of an investigator appointed or assigned by the Chair of the Leadership Council or Authority to investigate the **critical incident**, or a person designated by the Deputy Minister;
    g. the Chief Public Health Officer under the Public Health Act or a person authorized under that Act to make an inspection, investigation or inquiry for the Chief Public Health Officer;
    h. the Director of Child and Family Services under the *Child and Family Services Act*, or a Child Protection Worker or a peace officer or an authorized person if a Child Protection Worker is not available, information must be provided in respect of a child in need of protection;
    i. if the court says a person or body can see the report; or
    j. a person or body listed in the regulations as allowed to see the report.

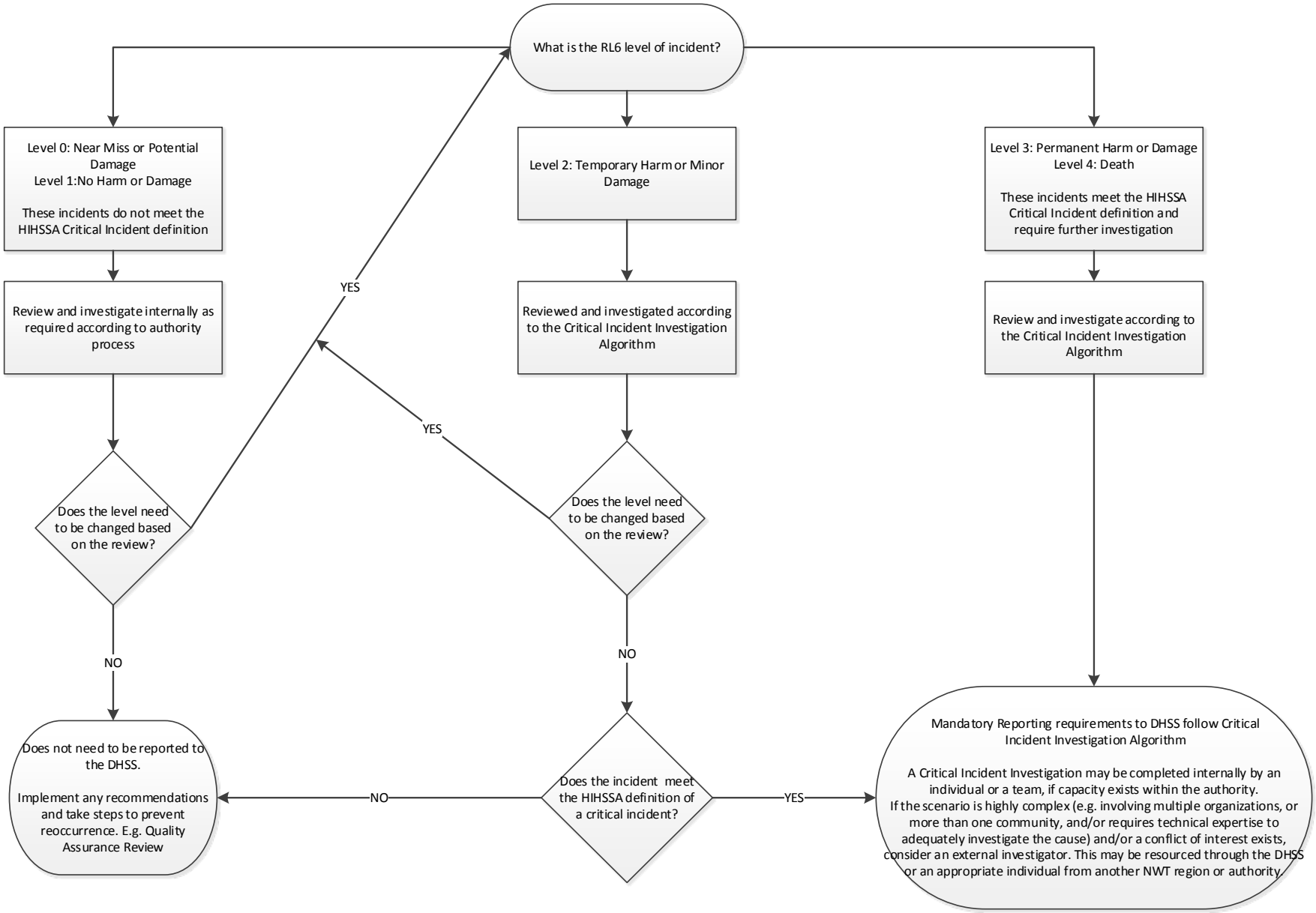
*There are provisions within HIHSSA that prevent the release of information gathered for the purposes of conducting a Critical Incident investigation. The investigation, findings, and the report are strictly confidential and no person is entitled under Access to Information and Protection of Privacy Act (ATIPP) or Health Information Act (HIA) to access these documents. However, the recommendations provided as a separate appendix of the report may be shared publicly so must not include any information that could be identifiable.*

## APPENDIX A

## Decision Pathway for Critical Incidents according to RL6

| RL6 Incident Definition | Recommendations for Critical Incident Investigation | Outcome of the Critical Incident Investigation | Individual Accountable | Timeline to complete |
|---|---|---|---|---|
| **Level 0**- Near Miss or Potential Damage<br>**Level 1**- No Harm or Damage | This does not meet the HIHSSA definition of Critical Incident.<br><br>Patient safety incidents managed by the Authority. Follow internal process and implement any recommendations and take steps to prevent reoccurrence. | Not Applicable | Determined by Authority. | Determined by Authority. |
| **Level 2**- Temporary Harm or Minor Damage | This may or may not meet the HIHSSA definition of a Critical Incident.<br>If it meets the definition then these incidents can be managed internally from the capacity (either an individual or team) that exists within the Authority depending on complexity. | An investigation report that follows the methodology as determined by the lead investigator and the appointing body.<br><br>This confidential report will contain a conclusion that identifies whether a critical incident occurred as well as separate recommendations attached as an appendix. Recommendations may be made public so these are not to include any personal identifiable information.<br><br>Section 25.3(1) of HIHSSA requires that the Minister be made aware of any critical incident or alleged critical incident. | The individual responsible for appointment of investigation (i.e.):<br><br>NTHSSA Leadership Council<br>**Or**<br>HRHSSA Public Administrator<br>**Or**<br>TCSA Board of Management<br>**And/or**<br>Minister of HSS | 90 days from when investigation was directed. |
| **Level 3**- Permanent Harm or Damage<br>**Level 4**- Death | This meets the HIHSSA definition of a Critical Incident therefore an investigation must ensue.<br><br>Highly complex incidents, including but not limited to incidents:<br>- involving multiple organizations or more than one community<br>-Media involvement<br>-Conflict of interest or the optics that one exists **and/or**<br>- That requires technical expertise to adequately investigate the cause.<br><br>These investigations should be managed by an external investigator with a multidisciplinary team (this may include support from the DHSS). | | | |

SEE FLOWCHART BELOW FOR FURTHER DECISION PATHWAY:


What is the RL6 level of incident?
Level 0: Near Miss or Potential Damage
Level 1:No Harm or Damage
These incidents do not meet the HIHSSA Critical Incident definition
Level 2: Temporary Harm or Minor Damage
Level 3: Permanent Harm or Damage
Level 4: Death
These incidents meet the HIHSSA Critical Incident definition and require further investigation
Review and investigate internally as required according to authority process
Reviewed and investigated according to the Critical Incident Investigation Algorithm
Review and investigate according to the Critical Incident Investigation Algorithm
YES
YES
Does the level need to be changed based on the review?
Does the level need to be changed based on the review?
NO
NO
Does not need to be reported to the DHSS.
Implement any recommendations and take steps to prevent reoccurrence. E.g. Quality Assurance Review
Does the incident meet the HIHSSA definition of a critical incident?
NO
YES
Mandatory Reporting requirements to DHSS follow Critical Incident Investigation Algorithm
A Critical Incident Investigation may be completed internally by an individual or a team, if capacity exists within the authority.
If the scenario is highly complex (e.g. involving multiple organizations, or more than one community, and/or requires technical expertise to adequately investigate the cause) and/or a conflict of interest exists, consider an external investigator. This may be resourced through the DHSS or an appropriate individual from another NWT region or authority.

## APPENDIX B

## Sample Summary of Findings Report[4]

This sample report is to assist the Authority with gathering the appropriate information to determine whether a critical incident notification to the Minister of Health and Social Services is required.

### Organization/Department (e.g. NTHSSA, HRHSSA, TCSA)

**Summary of Findings Report- Confidential Document**

**Event: Title the event including the date**

**Summary of Facts:**

Provide a brief objective synopsis of the incident that occurred. Include key events, relevant environmental conditions, emergent issues, other organizations or resources involved (e.g. Med-Response, Housing Corporation), immediate actions taken to address and remedy the incident, length of incident, and listing any staff, patient(s)/client(s), family, and/or visitors involved or who witnessed the incident.

**Background:**

Identify any relevant historical or situational information such as: past incidents, age/physical status of equipment, staffing levels, and past practices and information impacting planning and response.

**Chronology of Events:**

Provide a brief timeline of the incident as it emerged and the actions taken to address the incident. Professional observations and assessments of the incident are included here.

**Follow-Up:**

- Recommend if a critical incident (according to *HIHSSA* definition) notification is required (if this is determined, HIHSSA requires notification to the Minister). Propose further plans for investigation depending on the Decision Pathway for Critical Incidents according to RL6 (Appendix B).
- If not a critical incident, may wish to establish a quality assurance committee and provide recommendations based on this review process (e.g. training, policy review or modification, prevention measures, points of contact for future incidents, identify aspects that worked well, including any areas for improvement. information to support future response and planning).

Describe any post incident follow-up required (e.g. type of investigation required and proposed investigator, media requests, internal/external communications, ministerial briefings, notification to patient/client(s) and/or family, issue of apology, any physical and/or emotional supports necessary for patient/clients(s) and/or family etc.).

**Report Completed by:**

Name/Position:
Date:

[4] Adapted from Government of Nunavut. Department of Health: Draft *Client and Staff Safety Events- Reporting and Management.* December, 2016.

## APPENDIX C
## Sample Critical Incident Investigation Terms of Reference

Critical Incident Investigation

TERMS OF REFERENCE

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**Draft TOR will need to be reviewed by legal counsel.**

These Terms of Reference set out the parameters of a Critical Incident Investigation into the health services provided to [*Insert Patient/Client's Name*] at any facility in the Northwest Territories during [*Insert date(s)*].

The investigation will be conducted by an investigator appointed by the [*Insert who has appointed the Investigator e.g. Minister of Health and Social Services/CEO/COO/Public Administrator*] (the "*Insert Appointer Name*") pursuant to subsection 25.3(3) of *Hospital Insurance and Health and Social Services Administration Act* ("HIHSSA").

In addition to these Terms of Reference, the parameters set out in HIHSSA with respect to Critical Incident Investigations apply to the Critical Incident Investigation.

The term "critical incident" is defined pursuant to the definition in HIHSSA:

> "critical incident" means an unintended event that occurs when health services or social services provided to an individual result in a consequence to them that
>
> (a) is serious or undesired, such as
>
> (i) death, disability, injury or harm,
>
> (ii) an unplanned admission to a health facility or an unusual extension of a stay in a health facility, or
>
> (iii) a significant risk of substantial or serious harm to the safety, well-being or health of the individual, and
>
> (b) does not result from an underlying health condition of the individual or from a risk inherent in providing the health services or social services to them.

The term "facility" is the same as is defined in HIHSSA.

**1. PURPOSE**

As set out at section 25.3(4) of HIHSSA, the purpose of the critical incident investigation is to:

a) Review whether or not a critical incident occurred;

b) Review factors that may have caused or contributed to a critical incident; and
c) Prevent the occurrence of critical incidents in the future.

The Investigator will also address the following, in order to satisfy the purpose of the Critical Incident Investigation:

- Given the facts known at the time, was the clinical care provided to the individual appropriate and compliant with applicable clinical standards?
- If the clinical care provided to the individual was not appropriate or compliant with the clinical standards, what were the factors that may have caused or contributed to the critical incident?
- If the clinical care provided to the Patient/Client was not appropriate or compliant with the clinical standards, what are the recommendations to improve the quality of health services?

The Investigator, referenced in section 2.1, will produce a written Report of Findings and, if appropriate, an appendix to the Report of Findings with recommendations that the Investigator considers appropriate.

## 2. INVESTIGATOR

2.1 There will be [*number of investigators e.g. one (1)]* change if more) investigator/s, who will be referred to herein as the "Investigator".

2.2 The investigation will be led by [*Insert Name of Lead Investigator(s)*]. The Investigator will be assisted by a health professional who will provide information respecting the applicable practice standards and clinical protocols.

2.3 The Investigator will be appointed as an investigator under section 25.3 (3) of HIHSSA by the Minister. The Investigator will have all the powers and responsibilities of an investigator as outlined in sections 25.2, 25.3, 25.4, 25.5 and 25.6 of HIHSSA relating to critical incidents.

## 3. METHODOLODY

3.1The Investigator will be provided and will carry identification pursuant to section 25.6 (3) of HIHSSA and shall, on request, present it to a person who is requested to cooperate with this Critical Incident Investigation.

3.2The Investigator may make contact with any person who is responsible for or who works at a facility where the critical incident is alleged to have occurred and may request that he or she produce for examination any record or other thing requested

by the investigator for the purposes of the investigation. In accordance with s.25.3(5) of HIHSSA, those persons shall give the investigator all reasonable assistance to enable the investigator to conduct the investigation and provide the investigator with any information or explanations relevant to the investigation that the investigator may reasonably require.

3.3 The Investigator will examine all records relevant to the critical incident in possession of the facilities where the critical incident is alleged to have occurred and in the possession of every person who provided or assisted in providing a health service or social service that is the subject of the critical incident investigation, including all relevant entries on the Patient/Client's medical charts/counselling record pursuant to section 25.6 of HIHSSA.

3.4 The Investigator will conduct, or attempt to conduct, interviews with:

- any medical or professional staff, or personnel of the facilities, who have a duty to cooperate as per section 25.3(5) and who may have information about the health or social services provided to the Patient/Client, including former staff or personnel.
- Other parties or family members who may have information about the health services provided to the Patient/Client.

3.5 The Investigator will explain the critical incident investigation process to any individuals they interview. This will include, but is not limited to the following:

- Informing the individuals of the critical incident and the nature of the investigation and that the Investigator's purpose is to:
    - review whether or not a critical incident occurred,
    - review factors that may have caused or contributed to a critical incident;
    - prevent the occurrence of critical incidents in the future; and
    - evaluate the care provided to the Patient/Client by the staff or employees.
- Ensuring that the individuals are aware of the process the Investigator is following, and of the fact that a written Report with recommendations, if appropriate, will be produced for the [*Insert who has appointed the Investigator e.g. CEO/COO/ Public Administrator*] and the Minister.
- Informing the individuals who provided health or social services or who are responsible for a facility where health or social services were provided to the Patient/Client of their duty to cooperate pursuant to section 25.3 (5).
- Explaining the confidential nature of the investigation in accordance with section 25.4 of HIHSSA.

3.6 The Investigator will review all relevant documents that are publically available, including legislation and regulations, policies, protocols and procedures of the Northwest Territories Health and Social Services Authority and the Government of the Northwest Territories (GNWT), professional standards of practice and relevant best practice standards and documents pertaining to available community follow up programs and supports.

3.7 The Investigator will prepare a written Report, which will include: a summary of the process used to investigate this matter; a summary of the information gathered; a summary of the documents reviewed; and an analysis and findings. The Report may contain an Appendix with any recommendations that the Investigator considers appropriate. The recommendations shall not contain any identifying information of the parties involved or any information gathered or record produced by or for the investigator in the course of or for the purpose of the investigation.

3.8 The Investigator will provide regular briefings about the status of the investigation to the [*Insert the name of the designated person to report as determined by the CEO/COO/ Public Administrator/Minister*] determined by the [*Insert who has appointed the Investigator e.g. CEO/COO/ Public Administrator/Minister*].

3.9 Any questions the Investigator may have in regards to process or GNWT policy will be directed to the [*Insert the name of the designated person to report as determined by the CEO/COO/ Public Administrator/Minister*], or their alternate.

3.10 Appropriate administrative support will be provided by [Insert *who will be providing assistance e.g. the Authority or DHSS]* to the Investigator, as required.

## 4. CONFIDENTIALITY

4.1 The investigation proceedings and discussions, as well as any records of information in any form produced by or for the Investigator during the course of, or for the purpose of, this investigation, shall remain confidential, including during preparation for the investigation, and during and after the investigation.

4.2 The Investigator shall not provide any information gathered or record produced by or for the Investigator in the course of, or for the purpose of, this investigation, except in accordance with section 25.4(1)(c)(d), (2) and (3) of HIHSSA.

## 5. REPORTING

The Investigator will submit the Report and Appendices in both hard copy and [*or*] electronic PDF format, to the [*Insert who has appointed the Investigator e.g. CEO/COO/ Public Administrator*] and the Minister.

## 6. TIMELINE

6.1 The investigation will commence on [*Insert date(s)*] and will be completed in a timely manner.

6.2 The Investigator will make every effort to have the Report referred to in section 5 completed and submitted to the [*Insert who has appointed the Investigator e.g. CEO/COO/ Public Administrator*] and the Minister by [*Insert date(s)*].

_____ _____

[*Insert who has appointed the Investigator e.g. CEO/COO/ Public Administrator and/or the Minister*] Date

_____ _____

[*Insert Name of Lead Investigator(s)*] Date

## APPENDIX D

## Sample Notification Letters for Patient/Family and Staff

Dear [*Insert Patient/Client and or Family Addressee*],

[Sample letters should be reviewed by legal prior to being signed by the investigator, if required discuss with legal on how to add information on counselling supports available to those involved].

The [*Insert who has appointed the Investigator e.g. Minister of Health and Social Services/CEO/COO/Public Administrator*] has appointed me under the *Hospital Insurance and Health and Social Services Administration Act* (the "Act") to investigate an alleged critical incident surrounding the services provided to [*Insert Patient/Client's Name*].

As the Investigator, I would like to interview you and will be contacting you to set up a time and place. If you do not wish to be interviewed, you can let me know at that time.

The purpose of the investigation will be to:

a) Review whether or not a critical incident occurred;
b) Review factors that may have caused or contributed to a critical incident;
c) Prevent the occurrence of critical incidents in the future; and
d) Evaluate the care provided to [*Insert Patient/Client's Name*] by the staff or employees.

Interviews will be recorded and transcribed. If you decide after the interview is over that you have more information you want to provide, or if you want the chance to review the transcript of your interview, please contact [*Insert the name of the person to contact e.g. assistant name or investigator name*]. Please note that as part of the critical incident investigation, the content of all interviews must remain confidential in accordance with the Act.

When the investigation is completed, I will produce a written Report of Findings for the [*Insert who has appointed the Investigator e.g. Minister of Health and Social Services/CEO/COO/Public Administrator*]. The Report will include any recommendations that I consider appropriate. Recommendations will not include personal information or any details of what people said during the interviews. The [*Insert who has appointed the Investigator e.g. Minister of Health and Social Services/CEO/COO/Public Administrator*] intends to make the recommendations public.

*Please accept my most sincere condolences and deepest sympathy for your loss*.
Or
Please accept my sincere sympathy and concern for your recent experiences.

[*Insert Name of Lead Investigator*]

[*Signature of Lead Investigator*]

[*Insert date(s)*]

To: [*Insert Staff Member Interviewee*]

[Sample letters should be reviewed by legal prior to being signed by the investigator].

The [*Insert who has appointed the Investigator e.g. Minister of Health and Social Services/CEO/COO/Public Administrator*] has appointed me to investigate an alleged critical incident into the services provided to [*Insert Patient/Client's Name*] (the "Patient/Client") at any facility in the Northwest Territories.

As set out at section 25.3(5) of *Hospital Insurance and Health and Social Services Administration Act* (the "Act"), the purpose of the critical incident investigation is to:

a) Review whether or not a critical incident occurred;
b) Review factors that may have caused or contributed to a critical incident;
c) Prevent the occurrence of critical incidents in the future; and
d) Evaluate the care provided to the Patient/Client by the staff or employees.

As part of the investigation process, I will be interviewing individuals who may have information pertaining to the services provided to the Patient/Client. You have been identified as a medical or professional staff or other personnel who works at a facility where a critical incident is alleged to have occurred or who provided or assisted in providing a health service or social service that is the subject of this critical incident investigation. Section 25.3(5) of the Act provides that you shall produce for examination any record or other thing requested by the investigator for the purposes of the investigation, give the investigator all reasonable assistance to enable the investigation to be conducted and provide the investigator with any information or explanations relevant to the investigation that may reasonably be required. If you are a Member of the Union, you have the option of being accompanied at the interview by a Union Representative. If you are not a Member of the Union, you have the option of being accompanied by legal counsel or a representative of your choosing.

Your interview has been scheduled for:

[*Insert Date, Place, and Time of Interview*]

Please confirm your attendance at the scheduled interview by [*Insert date(s)*]. You may confirm your attendance by phoning [*Insert phone number*] or by email at [*insert email address*]. If you are unable to attend in person, please contact [*Insert the name of the person to contact e.g. assistant name or investigator name*] who will be providing administrative support to the investigation and a toll-free teleconference line will be provided.

Please be assured that the nature of the investigation is not to investigate the conduct of staff or employees but rather to find out whether a critical incident did indeed occur, and if so, what can be done to prevent it from reoccurring. The investigation proceedings and the content of all interviews are subject to the confidentiality and access to information provisions set out at sections 25.4 and 25.5 of the Act along with the provisions of the *Health Information Act*.

Interviews will be recorded and transcribed. If, after the interview is concluded, you have any further information you would like to provide, or if you would like to have the opportunity to review the transcript of the interview, please contact [*Insert the name of the person to contact e.g. assistant name or investigator name*].

Upon completion of all review activities, a written Report of Findings will be produced and provided to the [*Insert who has appointed the Investigator e.g. Minister of Health and Social Services/CEO/COO/Public Administrator*]. The report will include any recommendations considered appropriate to improve health and social service delivery. While the recommendations may be made public under HIHSSA, they cannot contain any personal identifiers or references to what was communicated during these interviews.

In accordance with the privacy and confidentiality provisions of the *Health Information Act,* this investigation and the personal health information it entails is to remain confidential, including the contents of this letter. Please refrain from discussing the investigation or interview with colleagues and others.

I recognize that this may be a stressful event and if you need assistance, feel free to contact the Government's Employee and Family Assistance Program (EFAP) at 1-844-880-9142 (English) or 1-844-880-9143 (French), should this be the case.

I thank you in advance for your open and frank cooperation in this investigation.

Sincerely,

[*Signature of Lead Investigator*]

[*Insert Name of Lead Investigator*]