MANAGEMENT OF CRITICAL INCIDENTS PROCEDURE: BREAST SCREENING

(Quality Management – SG 140)

Summary of Changes

	NEW	Previous
BC Cancer	Moved to Procedure template	June 2019, January 2018, July 2008

1. Introduction

As part of the commitment to continuous quality improvement in care and services to Breast Screening program participants, all Critical Incidents within the program are managed, documented, appropriately communicated and investigated promptly in a consistent and non-accusatory manner.

The management of any Critical Incident must be aligned with the BC Cancer policy, and includes:

- Immediate Crisis Management, and
- Case Review and Root Cause Analysis.

1.1. Focus

The purpose of this document is to outline the steps involved in the management of a Critical Incident.

1.2. Health Organization Site Applicability

All BC Cancer Breast Screening Program Centres

1.3. Practice Level

- All Breast Screening Centre Staff
- Client Services Centre

1.4. Definitions

Critical Incident: An incident resulting in serious harm to the participant or to BC Cancer, or the significant risk thereof including but not limited to diagnostic, reporting, communication errors.

Immediate Crisis Management: A process by which the centre staff immediately responds to an Incident, including actions within the first 24 hours of the Incident; attends to the needs of the participant and staff involved; secures the area; gathers facts and notifies all appropriate people.

Root Cause Analysis (RAC): Defined by the World Health Organization as a structured approach to incident analysis. Characteristics of a RCA include:

- Review by an inter-professional team knowledgeable about the processes involved in the event;
- Analysis of systems and processes rather than individual performance;

- Deep analysis using "what" and "why" probes until all aspects of the process are reviewed and contributing factors are considered;
- Identification of potential changes that could be made in systems or processes to improve performance and reduce the likelihood of similar adverse events or close calls in the future.[1]

1.5. Need to Know

Immediate Crisis Management is the responsibility of management of the involved centre. Case Review and Root Cause Analysis responsibility falls to the Breast Screening Quality Management Committee, as part of its routine quality assurance activities.

Mobile service management must identify an on-site staff designate for each mobile site.

1.6. Equipment and Supplies

- Health Authority or centre specific guidelines where applicable
- Unusual Occurrence Form

2. Procedure

2.1. Steps and Rationale

Workflow Step	#	Description	Role
Immediate Crisis Management by the Screening Centre	1.	Address the immediate needs of the participant and any individual accompanying the participant (i.e. family).	Centre Staff
	1.1	Address needs of staff, and any other affected individuals.	Centre Manager
	1.2	Immediately notify the: • Head of Imaging Department or delegate • Chief Radiologist or delegate • Client Services Manager and Provincial Practice Leader or program delegate	Centre Manager
	1.3	When applicable, Isolate and secure medication, supplies or equipment, which might have contributed to the incident.	Centre Staff
	1.4	When applicable, mark equipment with a "Do Not Use" sign if the incident is related to equipment malfunction. Contact Centre Program Physicist, as required.	Centre Staff
	1.5	Record the clinical aspects of the incident using Health Authority or centre specific guidelines where applicable.	Centre Manager Centre Staff

	1.6	Defer to Health Authority or Community Imaging Centre Risk Management Team for appropriate critical incidence handling.	Centre Manager
	1.7	Complete an *Unusual Occurrence Form* with incident details. Forward to the Client Services Manager and Provincial Practice Leader or program delegate.	Centre Manager
Incident Handling by BC Cancer Breast Screening Program	2	Upon the program being notified, the Critical Incident is communicated to: • Screening Operations Director • Chair, Breast Screening Quality Management Committee • VP, Population Oncology	Client Services Manager Provincial Practice Leader
	2.1	Gather and secure relevant participant information records, including images.	Client Services Manager Provincial Practice Leader
	2.2	Upon being notified, the Critical Incident is communicated to: • BC Cancer Risk Management • BC Cancer Patient Safety Learning System (PSLS)	Screening Operations Director or delegate
Incident Handling by Health Authority and Community Imaging Centre	3	Manage communication with the insurer, legal counsel, and/or Executive Team and Communications.	Centre's Risk Management Team
	3.1	When applicable, appoint a chairperson to lead the Case Review using the Root Cause Analysis methodology.	Screening Operations Director or delegate

2.2. Documentation

Record the clinical aspects of the incident using Health Authority or centre specific guidelines where applicable.

Complete an *Unusual Occurrence Form* with incident details. Forward to the Client Services Manager and Provincial Practice Leader via BreastScreeningQualityAssurance@bccancer.bc.ca or program delegate.

2.3. Patient/Client Education

Participant's Primary Care Provider is informed first by the Centre Manager of the incident and when applicable by the Program of any impacts to patient care related to participant's health, records and/or changes in their reports/results and is advised to follow up with the patient accordingly.

3. Related Documents and References

3.1. Related Documents

Breast Screening Unusual Occurrence Form

SA 030 – Unusual Occurrences, Incident Reporting and Feedback Handling Policy

PHSA IA 100 – Managing Privacy and Confidentiality Breaches

PHSA POLICY #C-99-11-20533 - Patient Safety Event Management and Review Policy

PHSA Critical and Non-Critical Patient Safety Event Review Procedure

PHSA Stop the Line to Ensure Patient Safety

PHSA Stop the Line: Authority to Intervene to Ensure Patient Safety Procedure

PHSA Patient Safety Culture

PHSA Disclosure of Patient Safety Events

3.2. References

1. World Health Organization, Doc: 1.10.A – Root Cause Analysis, 2012. https://cdn.who.int/media/docs/default-source/patient-safety/curriculum-guide/resources/ps-curr-handouts/course05a_handout_root-cause-analysis.pdf?sfvrsn=d2615028_9&download=true

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	Amanda Hunter	Updated procedure, inclusion of procedure steps and roles.	16-MARCH-2023