islandcommunity services

Critical Incidents and Complaints Analysis Report - 2023

Incident Reports 2023

	2023	*2022*
Staffed Residential Med Error Program	29	*15*
Staffed Residential Med Error Pharmacy	4	*5*
Staffed Residential Health Issues	5	*11*
Staffed Residential Staff Injury	1	*2*
Staffed Residential Fall	5	*2*
Staffed Residential Injury	1	*1*
Staffed Residential Aggressive Behavior	0	*1*
Staffed Residential Dangerous Object/Weapon	0	*1*
Staffed Residential Missing Person	1	*0*
Day Programming Health Issues	3	*2*
Day Programming Injury	0	*1*
Day Programming Staff Injury	0	*3*
Day Programming Aggressive Behavior	0	*1*
Day Programming Fall	2	*0*
Housing Support injury	1	*0*
Food Bank Injury	0	*3*
Emergency Shelter Health Issues	1	*1*
Emergency Shelter Aggressive Behavior	4	*2*
Emergency Shelter Fall	1	*0*
Housing First Outreach Aggressive Behavior	0	*7*
Housing First Outreach Health issues	5	*7*
Housing First Staff Injury	1	*0*
Main BLDG/Admin Aggressive Behavior	2	*2*
Seniors Staff Injury	1	*0*
Recycle Depot Staff Injury	2	*0*
CYSN Aggressive Behavior	3	*0*
Total Incidents reported 2022	**72**	*67*

Complaints and Suggestions 2023

5 formal Complaints and Suggestions were submitted during 2023. 4 were from Emergency Shelter users expressing concerns about the manner in which they spoken to by Shelter staff.

One was from an individual connecting with the Housing First service who expressed they were unable to receive the help needed and expected. Responding to this particular complaint was quite prolonged, and escalated through every organizational level to the Board.

Comments and Analysis:

Critical Incident reports for 2023 increased slightly from 67 to 72**.**

All of the incident reports were reviewed by the Joint Safety and Health Committee, with specific recommendations and follow up as determined on an individual basis.

WorkSafe BC claims were completed as required for each of the 5 incidents of staff injury. These injuries varied in nature. 2 additional WorkSafe claims were made for staff injury that were not connected to critical incidents, but rather nagging cumulative injury for older staff who have been performing physical caregiving roles for years.

There was a decrease in serious health issues this year in the Staffed Residential program thankfully.

Staffed Residential medication errors were by far the most frequent incidents, making up about 40% of total. As with last year it is noted that they were all of a minor nature (timing, missing one dose, misplaced or lost pill). Any medication error that results in an adverse effect are incidents of a more serious nature requiring further actions and reporting. There is likely a trend of seeing even more diligent reporting in this area in an effort to address med errors. (eg. Some incident reports were of medication administration being off schedule by less than 30 minutes). There were still many straightforward and avoidable errors, however.

New enhanced day programming in the CYSN (Children and Youth with Special Needs) program was the source of 3 new incidents.

Of all the incidents, once again none involved serious injury or death.

There were an additional 24 Incident Reports completed by staff that once reviewed did not meet the criteria of being a critical incident. Each of these were still treated seriously and routed back to program coordinators and staff teams to address from a service delivery perspective (eg. Verbal conflicts between persons served, behavior of persons served being observed in the community).

A review of the Complaints and Suggestions submitted was done at a program level. Shelter staff have been encouraged and supported to be welcoming and open-minded about receiving complaints. The complaint that was escalated through each level, and ultimately to the Board, has prompted the Board to review its procedures or handling complaints making it to their table.

Follow Up:

1. A change has been made to direct Medication Errors in a different way than through the critical incident/H&S Committee process.
2. The Board is undertaking a review of policies and procedures for responding to complaints they receive.
3. Continue to fine-tune incident reporting procedures and provide staff training. It is suspected there may be some minor incidents that were not reported in some program areas, and would have offered good learning for ongoing preventative health and safety measures.
4. Provide positive feedback to staff for their care and attention in going through a busy year of service delivery without a major incident.
5. Provide positive feedback to staff for attending quickly and properly to incidents as they arise. Incident reports indicate very effective responses, and there were no cases in which staff made no response or an improper response.
6. Increase staff training for medication management, and review systems in the staffed residential program to reduce errors. A strategy is in place to require staff making repeated errors complete basic training.
7. Prioritize training and support in managing difficult individuals and difficult situations for Housing First Outreach and Emergency Shelter programs.
8. Include the principles and practices of Trauma-Informed Care in the orientation and training of emergency shelter staff, as well as emphasizing the need for consistency in approach and limit-setting among staff team members.