# Patient Safety Events Neonatal Program

## Determine Level of Harm

<table>
<thead>
<tr>
<th>Near Miss</th>
<th>No Harm</th>
<th>Harm has Reached the Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>A good catch or accident waiting to happen that was prevented.</td>
<td>An event which has the potential to cause serious physical or psychological injury, unexpected death, or significant property damage, but did not happen due to chance, corrective action, and/or timely intervention</td>
<td>Minor Harm: Increased monitoring to ensure recovery</td>
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<tr>
<td>Moderate Harm: Treatment required to recover</td>
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<td></td>
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<tr>
<td>Severe Harm: Extensive treatment to recover, long term complications</td>
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<td></td>
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<tr>
<td>Death</td>
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</tbody>
</table>

### Examples

- **Near Miss**
  - Wrong patient requisition found at bedside
  - Incorrect labelled EBM container found in patient bin in fridge/freezer
  - Wrong med found in patient med drawer

- **No Harm**
  - Wrong med dose given with no effect on patient
  - Monitor found to stop working when attached to patient
  - IV solution found to be leaking via cap into bed
  - Alarm rings occlusion as line was clamped
  - Device used for function other than its intended patient use

- **Harm has Reached the Patient**
  - Unexpected outcome/iatrogenic injury/death
  - Mis-identification of patient-intervention to the wrong patient.
  - Burns/lacerations/pressure ulcers/trauma
  - Delay to monitor/recognize/treat resulting in acute deterioration or death
  - Complications related to vascular or arterial access
  - Accidental extubations
  - Iatrogenic injuries related to respiratory care
  - Safety events related to equipment or products
  - Communication breakdown critical to provide care
  - Iatrogenic injury related to medication/TPN/IV/Blood administration errors.

### What not to Report?

- **Workplace Health & Safety** issues (speak to PC-call number on posters throughout the unit)
- **Lost property** (speak to CNL/PC)
- **Narcotic count discrepancies** - with no patient involved (notify PC)
- **Performance concerns** (discuss with CNL/PC)
- **Privacy Breaches** without a patient safety component (speak to PC)

### Complete PSLS Report

- **Document** what has occurred and subsequent care in the chart... **Notify** the Physician/CNL... **Treat** the patient for recovery
- If PSLS is submitted with contact information, an email explaining how you can follow-up on the report using the assigned reference number will occur and a later email will be sent to explain what was the outcome/improvements from reporting the event.
- **Need more assistance:** Contact CRN/Educator/CNL/PC/Quality & Safety Leader

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**Legend:**
- EBM=Expressed Breast Milk
- med=medication
- IV=intravenous
- TPN=Total Parenteral Nutrition
- CNL= Clinical Nurse Leader
- CRN= Clinical Resource Nurse
- PC= Program Coordinator
- PSLS= Patient Safety Learning System