UNITY HEALTH TORONTO

Serious Safety Event Review Process

Frontline staff

Patient safety event reported with serious level of harm

Local leadership

Initial event review completed by Patient Safety with **local leadership** to identify whether gap(s) from internal/published standards present.

Patient Safety

Event reviewed by the Patient Safety Team at the weekly **Patient Safety Case Review Meeting** to determine if they *most likely* meet the **Serious Safety Event (SSE)** 1-4 criteria.

Event Review Committee (ERC)

SSE 1: **Gaps identified causing Death**
SSE 2: **Gaps identified causing Severe Permanent Harm**
SSE 3: **Gaps identified causing Moderate Permanent Harm**
SSE 4: **Gaps identified causing Severe Temporary Harm**

Events most likely meeting SSE 1-4 criteria are then reviewed by the **Event Review Committee (ERC)** to confirm that they meet SSE 1-4 criteria and are therefore **Potential Critical Incidents.**

Program leadership

A Patient Safety System Review* is required and completed for *all* Potential Critical Incidents under the Public Hospitals Act including **input from the patient/family**. All requests for quality of care reviews from the Coroner are automatically reviewed as Potential Critical Incidents.

***to be completed within 90 days of ERC decision**

Patient/family

Executive team

Results of Patient Safety System Review are shared with:

1. **ERC** and **Executives** for feedback on action items and whether event meets SSE 1-4 (**Critical Incident**) criteria.
2. **Patient/family** as part of a required secondary disclosure and to let them know what we did in response to the event.

Patient Safety

Patient Safety monitors completion of action item(s).