



Annual Critical Incident Report August 2007-2008

Critical Incident Report August 2007 to July 2008

Breakdown of Incident Reports By Type – August 2007 to July 2008

Aggression by Client	Community Housing	Orchard House	24
		16 th Avenue	3
		Purcell Place	2
	Community Integration	Community Support	4
		8 th Ave Day Program	1
	<u>Supported Living</u>	<u>Scott Street</u>	<u>2</u>
	Total	36	
Client Injury (Fall)	Community Housing	Purcell Place	15
		25 th Avenue	11
		Orchard House	3
		16 th Avenue	1
		Orchard Apt	2
	Community Integration	10 th Ave Day Program	4
		8 th Ave Day Program	3
	Supported Living	Scott Street	1
		Cook Street	1
		8 th Avenue	1
	<u>Therapeutic Riding Program</u>	<u>2</u>	
	Total	45	
Client Injury (Other)	Community Housing	Orchard House	16
		Purcell Place	6
		25 th Avenue	5
		Orchard Apt	1
	Community Integration	8 th Ave Day Program	2
		10 th Ave Day Program	2
	<u>Therapeutic Riding Program</u>	<u>1</u>	
	Total	33	
Client Illness	Community Housing	Orchard House	3
		25 th Avenue	4
	<u>Supported Living</u>	<u>Scott Street</u>	<u>4</u>
		Total	10

Emergency (Fire) (Missing Person) (Fire) (RCMP Standoff) (Water Leak) (Water Leak)	Community Housing	Orchard Apt	1
		Orchard House	1
	Supported Living	Hillside (Reb. Manor)	1
		8 th Avenue	1
		Cook Street	1
		8 th Avenue	1
	<u>Total</u>		6

Medication Errors	Community Housing	Orchard House	7
		16 th Avenue	1
		Purcell Place	2
		25 th Avenue	1
	Supported Living	Scott Street	19
		8 th Avenue	1
	<u>Total</u>		31

(Medication Error Reports were forwarded to the Medication Safety Committee)

Staff Injury	Community Housing	Orchard House	22
		16 th Avenue	1
		25 th Avenue	1
		Purcell Place	2
	Community Integration	10 th Ave Day Program	1
	<u>Supported Living</u>	Scott Street	1
	<u>Total</u>		28

Other (Vandalism) (Missed Med Appt) (Fraud by Client)	Therapeutic Riding Program		1
	Supported Living	Scott Street	1
		Scott Street	1
<u>Total</u>			3



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All Incident Reports are reviewed and signed by the appropriate Coordinator and the Executive Director. Copies of all Incident Reports are sent to the Consulting Health Services for Community Living (HSCL) Nurse. Serious Incidents are also reported to the Community Living BC Analyst and the Community Care and Licensing Officer (for Licensed facilities).

All incidents involving staff and clients are reviewed by the Safety and Health Committee on a regular basis. Recommendations are made to Coordinators as deemed necessary and discussed at the Management Team level where needed. Incidents involving Medication Errors are forwarded to the Medication Safety Committee for review.

Trends and Recommendations

1) Aggression from Clients

There was a high number of Incident Reports regarding aggression by clients at Orchard House. A number of these involved altercations between clients, but 22 resulted in staff injuries of varying degrees. This included two WCB claims for employees who were injured in July 2008 as a result of aggression. Measures that have been undertaken include medication reviews, involvement of professional assistance from the Consulting Nurse and Developmental Disability Mental Health Services, consultation with physicians and specialists and review and revision of procedures and protocols for dealing with acts of aggression. Staff have also tried various strategies including rearranging the furniture and traffic flow areas of the home and having two clients switch places. It is noted that the number of incidents have decreased in August and September. This is a large area of concern.

Recommendation:

For the Coordinator at Orchard House and staff to continue to monitor the situation and work with health professionals to reduce the risk of injury from client aggression through various means.

2) Client Injuries from Falls

It was noted that there were a fair number of incidents involving falls by clients at Purcell Place and 25th Avenue. These mainly involved clients who are inclined to have falls due to health issues and/or physical disabilities.

No Recommendations

3) Medication Errors

There were a substantial number of Medication Errors at Scott Street over the last year. Most of these involved missed eye drops, mostly in the morning. Measures have been put in place by the Coordinator to reduce the number of errors. These include providing clear protocols and procedures for the morning shift and ensuring that there are staff available to administer the drops when needed.

Recommendation: To continue to monitor the number of Medication Errors at Scott Street.

See breakdown of Incident Reports attached.