University of Prince Edward Island	Policy Number: 0001		
Policy Title: Reporting of Clinical Incidents, Medication Errors, and Near Misses	Pages: 4		
Authority: Faculty of Nursing	Creation Date: February 2003		
Reference: Adapted from Queens University, 2003	Version Date: January 2025		
	Review Date: January 2029		

1. Purpose

- a) To document the type and frequency of incidents, including those involving medications, which occur during student clinical experiences in order to identify, analyze, and take action.
- b) To track the number and severity of all clinical and medication incidents and share confidential copies to UPEI's Health, Safety, and Environment (HSE) Department.
- c) To serve as an educational tool to assist faculty to detect gaps in understanding and direct necessary changes in the educational program.
- d) To support student learning and self-reflection.
- e) To provide supporting documentation relevant to the student's clinical experience in the program.
- f) To enable UPEI Health, Safety and Environment Department's records management and administration of Provincial Occupational Health and Safety Legislation.

2. Scope

All students enrolled in the baccalaureate and graduate nursing programs.

3. Responsibility

Faculty of Nursing

4. Policy

Definitions

Clinical Incident: Any occurrence which is not in accord with the routine operation of the institution or the routine care of a particular patient/client. It may involve a patient/client, staff member, student, visitor or all four. It could also involve supplies, equipment, procedures, or particular services or programs.

Clinical Discrepancy: An error has been detected and corrected before an incident happened. This also qualifies as a clinical incident (near miss*).

Medication Error: An event which involves an error in the administration of a drug (e.g., wrong dose) to a patient, or lack of administration of a prescribed drug to a patient.

Medication Discrepancy: an event which does not involve the actual administration of a drug to a patient, but where an error in the medication process has been detected and corrected before reaching the patient (near miss*).

*The College of Registered Nurses and Midwives of Prince Edward Island (CRNMPEI, formerly CRNPEI) cites a near miss from the Canadian Patient Safety Institute (2009 [2nd edition 2020]) as "An event with the potential for harm that did not result in harm because it did not reach the patient due to timely intervention or good fortune. The term "good catch" is a common colloquialism to indicate the just-in-time detection of a potential adverse event" (CRNPEI, 2019, p. 17).

Reporting Guidelines and Procedures:

The guidelines and procedures are informed by the Canadian Nurses Protective Society (2021) resource about medication errors. The following guidelines are to be followed when completing an incident report (Appendix A): Documentation about the incident should be objective and contain factual information only.

- a) Normally, reports are to be completed by the person directly involved in or present at the time of the incident or discrepancy, i.e., student or Faculty/Clinical Nursing Instructor (CNI). When a student is under the supervision of a preceptor/instructor, the Course Coordinator is to be notified of the incident as soon as possible.
- b) The report will be sent to the Course Coordinator (CC) who will review and sign and give it to an Administrative Assistant (AA). The AA or CC will forward a scanned copy to UPEI Health, Safety and Environment Department, and ensure the original copy is placed in the student file.

UPEI incident reports are to be initiated and emailed/delivered to HSE within 24hrs of the incident occurring, so any actions by Faculty of Nursing/HSE (if needed) are timely.

5. Review

This policy will be reviewed in January 2029 and every 4 years thereafter, or whenever deemed necessary.

6. References

CRNPEI (2019). Entry level competencies for Registered Nurses. Retrieved from:

https://immediac.blob.core.windows.net/crnpei/pdf/Entry%20Level%20Competencies%202019.pdf

Canadian Nurses Protective Society (2021). InfoLAW: *Medication errors*. Retrieved from: https://cnps.ca/article/medication-errors/

Canadian Patient Safety Institute (2020). *The safety competencies. Enhancing patient safety across the health professions.* (2nd ed.). Retrieved from: https://www.healthcareexcellence.ca/media/115mbc4z/cpsi-safetycompetencies_en_digital-final-ua.pdf

APPENDIX A

UPEI FACULTY OF NURSING CLINICAL INCIDENT REPORT

This form is to be completed by the student.

Date and Time of Incident					
Name of Student: E-mail:					
Phone:					
r:					
signa	ated:				
 it:					
ncide	ent?				
le)	Patient	Student Nurse	Visitor	Staff	Other
Agency Incident Form completed? (circle)					
		-			
Na	Name		Title		
	ncide	signated: at: ncident? le) Patient mpleted? (circle)	signated: at: ncident? le) Patient Student Nurse mpleted? (circle) Yes	signated: at: ncident? le) Patient Student Visitor mpleted? (circle) Yes No	signated: at: ncident? le) Patient Student Visitor Staff mpleted? (circle) Yes No

Student describes what actions occurred once the incident was noted:	
Student describes the consequences or potential consequences related to the incident:	
Student's recommendations to prevent re-occurrence:	
Recommendations from CNI and/or Course Coordinator	

Student Signature:	-		
Date:			
Clinical Nursing Instruc	tor/Preceptor:		
Date:			
Course Coordinator:			
Date:			

Protection of Privacy

The personal information requested on this form is collected under the authority of Section 31(c) of the PEI *Freedom of Information and Protection of Privacy Act* and will be protected under Part 2 of that *Act*. It will be used for the purpose of [state specific uses for which the information is collected].

Direct any questions about this collection to:

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