(6) Critical and Reportable Incidents

(a) A critical incident is a serious adverse health or procedural event that was unexpected or unanticipated and did not necessarily result from known risks inherent of the procedure that occurred during the provision of any authorized

practices.

(b) A reportable incident is an unexpected and unanticipated event resulting in the need for transfer of the care of the patient to another provider, a non-hospital surgical facility, or hospital.

(c) It is mandatory that such critical and reportable incidents be reported to the Registrar by a written report from the responsible registrant in a timely manner, within 48 hours of the incident, in an attempt to identify and mitigate potential risks and harms.

(d) The mandatory reporting is for quality assurance purposes only, is confidential, and is prohibited from being used as evidence in professional conduct or legal proceedings.

(e) The intention of critical incident reporting is to lead to improvements in patient care and safety and encourage trust in the health care system through transparency.

(f) The written report must contain the following:
   (i) Name, age, and gender of the patient;
   (ii) Medical history of the patient;
   (iii) Name of witness(es) to the incident;
   (iv) Date of procedure;
   (v) Type of procedure;
   (vi) Nature of the incident;
   (vii) Management of the incident;
   (viii) Analysis of reasons for the incident;
   (ix) Action proposals to mitigate the repetition of such incident.

(g) The Quality Assurance Committee will:
   (i) investigate and review the incident with the registrant;
   (ii) assist the registrant with best practices to mitigate the repetition of the incident;
   (iii) maintain a register of critical incidents;
   (iv) and provide an annual report of critical incidents to the Council.