**Supplementary materials**

**Table S1**. Essential Elements of Legislation for Patient Safety Incident Reporting

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| --- | --- |
| Element | Summary |
| 1. What is reported?
 | The definition of a reportable incident(s) is clearly defined. |
| 1. Who makes a report?
 | The group of persons (e.g., healthcare professionals, employees of healthcare institutions, patients, and families) who report is defined, and incident reporting mechanisms for persons outside the defined group are provided. |
| 1. How is an incident reported?
 | Procedures and timelines for reporting and investigation are defined. |
| 1. To whom is an incident reported?
 | Reports, including personal health information, to a patient safety incident review committee should be required by healthcare professionals or institutions. Reporting to the health ministry (or prescribed organisation) should also be required for tracking and analysis. |
| 1. Confidentiality
 | Reported information must exclude the name of the patient, healthcare provider, or the name of any other individual with knowledge of the incident. |
| 1. Protection in legal proceedings
 | All documentation resulting from the patient safety incident review process is protected and therefore not permitted as evidence in legal proceedings. |
| 1. Non-retaliation
 | Persons who provide information are protected from personal liability, suspension, demotion, harassment, and other retaliatory behaviour. |
| 1. Expert analysis
 | Critical issues described in reports must be reviewed by experts who have appropriate clinical skills and knowledge of system issues. |
| 1. Incidents register
 | The minister or other prescribed organisation must maintain a register of incidents on a de-identified basis for the purpose of aggregating and sharing data at the jurisdictional level. Legislation should encourage the use of electronic reporting systems. |
| 1. Annual review
 | Institutions must report to the responsible minister or other prescribed organisation, summarising the reporting and recommendations, on an annual basis. The summary must include a report on the implementation of quality improvement recommendations of the previous year, including evaluation of success. |

Adapted from Baker et al., 2008, p. B16-17

**Table S2.** Select Literature Review Findings

| Citation | Methods | Legislation  | Conclusion |
| --- | --- | --- | --- |
| Daneman et al., 2012 | **Design:** Retrospective, longitudinal population-based cohort study**Data sources:** Administrative data**Study period:** April 1, 2002 and March 31, 2010**Setting:** 180 Acute Care Hospitals in Ontario | Mandatory public reporting | Public reporting associated with statistically significant reductions in *C. difficile* rates.**Comments:** Future research required to determine by which mechanism *C. difficile* rates were reduced in response to public reporting. |
| Haustein et al., 2011 | **Design:** Retrospective cross-sectional study**Data sources:** Administrative data**Study period:** 2011**Setting:** USA, England, France, and Germany  | Mandatory public reporting, and mandatory confidential reporting | Inconclusive. No significant impact of legislation on healthcare-associated infections (HAI).**Comments:** Legislation has been associated with organisational changes, but not enough evidence exists to conclude whether legislation had a statistically significant impact on patient safety outcomes. |
| Linkin et al., 2013 | **Design:** Cross-sectional study**Data sources:** Survey data**Study period:** May - June 2011**Setting:** 137 U.S. SHEA-RN primary investigator sites  | Mandatory public reporting | No impact or association of legislation with perceived improvements in infection prevention program process measures or HAI rates**Comments:** This study mainly featured large, academic hospitals with infection control protocols, meaning these sites represent a group that is vigorously combating HAIs regardless of reporting. |
| Lucet et al., 2013 | **Design:** Synthesis**Data sources:** Administrative data**Study period:** 2010-2012**Setting:** Hospitals in France | Mandatory reporting in some jurisdictions; Mandatory surveillance in others | Inconclusive. |
| Marsteller et al., 2014 | **Design:** Retrospective cohort study**Data sources:** *On the CUSP: Stop BSI* program participant CLABSI data**Study period:** 2009-2011**Setting:** Adult intensive care units in 44 states across the U.S. | Mandatory public reporting | No statistically significant impact of legislation on outcomes or rates.**Comments:** Reporting requirements do not teach sites how to reduce rates. |
| Pakyz et al., 2013 | **Design:** Cross-sectional study**Data sources:** Hospital-level administrative and U.S. Health and Human Services Hospital Compare website data**Study period:** 2011**Setting:** U.S. academic hospitals within the University Health System Consortium  | Mandatory public reporting | No evidence of impact of state legislation on CLABSI occurrence.**Comments:** Impact of state legislation may be lessened by other patient incident-prevention initiatives. |
| Stone et al., 2007 | **Design:** Retrospective longitudinal cross-sectional study**Data sources:** Multi-hospital patient safety data**Study period:** 2002**Setting:** 41 Intensive care units in 24 U.S. hospitals  | Mandatory public reporting of all infections | HAI Reports generated by different reporting methods vary widely. Mandatory reporting mechanisms and processes should be standardised, and their accuracy confirmed. |
| Stone et al., 2011 | **Design:** Longitudinal mixed methods study**Data sources:** Primary interview and administrative data**Study period:** 2008-2010**Setting:** Hospitals in California, U.S. | Mandatory public reporting | Significant increase in adoption of and adherence to evidence-based practices and decreased HAI rates. **Comments:** Mandatory reporting had intended and unintended consequences. This study shows that technology and organisational factors are extremely important in preventing patient incidents. |
| Stone et al., 2015 | **Design:** Qualitative public health law study**Data sources:** Semi-structured interviews**Study period:** 2012**Setting:** 12 U.S. States, 6 with mandatory reporting laws, 6 without | Mandatory reporting (Arkansas, Colorado, New York, Ohio, Tennessee, and Texas); and no legislation (Arizona, Georgia, Kansas, Kentucky, Nebraska, and Wisconsin) | Limited evidence, inconclusive.**Comments**: In theory, value-based purchasing programs (based on legislation that allowed Medicare to pay hospitals for reporting quality measures, rather than on service or patient counts) should be associated with decreasing instances of patient incidents. |
| Woodward et al., 2016 | **Design:** Retrospective chart review**Data sources:** Administrative data**Study period:** 2008, 2012, and 2015**Setting:** Intensive care units in southeast U.S.  | Mandatory reporting | Limited evidence.**Comments:** Larger sample over longer period needed to draw conclusions about the impact of legislation on patient safety outcomes and rates. |

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# Expert Informants and Interview Guide

A purposive sample of expert informants working in patient safety and quality of care in different jurisdictions of Canada were invited to participate in interviews. Interviews were sought in one jurisdiction without mandatory reporting legislation (i.e., Alberta) and two jurisdictions with mandatory reporting legislation that appeared to follow contrasting approaches to implementation (i.e., British Columbia and Ontario).

Between March 13 and May 13, 2019, inclusive, we conducted semi-structured interviews with 13 informants. These were relatively informal conversations with senior executives and practitioners in the field that provided contextual and experiential evidence to clarify and understand the interpretation and implementation of legislation on patient safety in general, and mandatory reporting specifically. Contributions from these experts are integrated throughout the findings and recommendations of this report.

#### **Table S3.** Organisations Represented by Expert Informants

|  |  |
| --- | --- |
| Jurisdiction | Organisation |
| British Columbia | BC Patient Safety and Quality CouncilBC Patient Safety Learning System Central OfficeCollege of Physicians and Surgeons of BCBC College of Nursing ProfessionalsCollege of Pharmacists of BC |
| Alberta | Health Quality Council of AlbertaUniversity of Calgary |
| Ontario | Sinai Health SystemSickKids Children’s HospitalOntario Hospital AssociationOntario College of Family PhysiciansOntario College of Pharmacists |

Through our professional networks and recommendations from some of the expert informants we spoke with, we identified a purposive sample of senior executives and practitioners in the field of patient safety. Invitations to interview and scheduling were arranged by email. Information about the project, including preliminary findings and interview questions, were shared in advance. Two of the authors shared responsibility for conducting the interviews, which were done over the phone. Each interview began with a review of the project and preliminary findings, allowing the informant to provide feedback before questions from the interview guide were asked. The interviews were semi-structured and tailored to each informant and their context, so not all questions were asked in all interviews.

##### Semi-structured interview guide

1. What is your impression of patient safety legislation (including statutes and regulations) in your jurisdiction?
2. How would you assess the strength/weakness of current patient safety legislation in your jurisdiction (with regard to mandatory reporting and beyond)?
3. What elements might enhance the impact of patient safety legislation?
4. Are there any constraints of current legislation?
5. How does your jurisdiction’s legislation compare to others’?
6. How does legislation fit within broader patient safety efforts?
7. What role(s) and responsibilities does your profession/regulatory body hold with regard to patient safety?
* Where do these roles and responsibilities come from? Are they determined within the province or by a national body? Are they influenced by legislation?
1. Are there mechanisms used to regulate patient safety in your profession? If yes, what are they?
* What are the strengths of current patient safety standards or guidelines within your profession?
1. Has the College adopted any guidelines related to patient safety?
* How are these implemented in practice?
* How are they enforced?
1. To what extent are patient safety standards or guidelines aligned with legislation? How are they implemented in practice? What are the opportunities for improvement?
2. Does your profession/regulatory body face any constraints or challenges with regard to supporting patient safety?
* What is your impression of patient safety legislation in your province (specifically with regard to mandatory reporting)?
1. What, in your view, could enhance the impact of your profession/regulatory body on patient safety?
2. Is there anything else you would like to add?
3. Is there anyone you recommend we speak to regarding a) an assessment of your jurisdiction’s legislation, or b) professional regulation for patient safety?

#### **Table S4.** Assessment of Legislation by Jurisdiction

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| **Element 1: Detail on what is reported** |
| BC (2013) | *Hospital Act* ss. 21(1): Duty to report "serious adverse event"1 in hospitals only. |
| SK (2004) | *The Provincial Health Authority Act*, ss. 8-2: Health service providers, provincial health authority and the cancer agency must report critical incidents2. |
| MB (2005) | *Regional Health Authorities Act,* ss. 53.2(1): Regional health authorities, health corporations and prescribed healthcare organisations must establish written procedures respecting providing information about and recording critical incidents1 as per 53.2(2). |
| ON (2011) | *Hospital Management Regulation, ss. 1, 2(4):* Hospital administrators must report every critical incident.2 |
| QC (2002) | *An Act Respecting Health Services and Social Services,* ss. 8, 183.2, 233.I: Any person must report an incident or accident2 as soon as possible. |
| NB (2018) | *Health Quality and Patient Safety Act,* c. 21, ss 1-3: All patient safety incidents2 must be reported. |
| NL (2017) | *Patient Safety Act*, c. P-3.01, ss. 4-5: All occurrences and close calls must be reported.2 |
| NT (2016) | *Hospital Insurance and Health and Social Services Administration Act*, ss. 25.2.1: All critical incidents2 must be reported. |
| **Element 2: Detail on who makes a report** |
| BC (2013) | *Hospital Act* s 21(2): The hospital administrator (or licensee of a private hospital) must report. |
| SK (2004) | *The Provincial Health Authority Act,* ss. 8-2: Health service providers, provincial health authority and the cancer agency must report critical incidents. Individual health service providers report to provincial health authority, which reports to minister, investigates and reports again to minister. No provisions stated for persons outside defined group to report incidents. |
| MB (2005) | *Regional Health Authorities Act*, 53.2-53.3, 53.4.1(1): A regional health authority, health corporation or prescribed healthcare organisation must report critical incidents. The regional health authority must notify the minister. Designated organisations (e.g., Shared Health, CancerCare Manitoba) notify and report directly to the minister. Other individuals that may notify the regional health authority, health corporation or prescribed organisation of a critical incident include patients, relatives of a patient or an individual working at or for the regional health authority, the health corporation or the prescribed organisation. |
| ON (2011) | *Hospital Management Regulation, ss. 2(4):* The hospital administrator must establish a system to ensure reporting of every critical incident as soon as possible to the medical advisory committee and administrator. However, no provisions were found to describe these systems or define who makes a report. |
| QC (2002) | *An Act Respecting Health Services and Social Services*, s. 233.I: Any person (an employee or other person on contract or undergoing training at the institution) must report an incident or accident. The executive director of the institution or other designate will regularly report in non-nominative form all incidents to the relevant agency at agreed intervals or whenever the agency so requires. No provisions stated for persons outside defined group to report incidents. |
| NB (2018) | *Health Quality and Patient Safety Act*, c. 21, ss 3: The healthcare organisation that provided the health services shall report any patient safety incident. |
| NL (2017) | *Patient Safety Act,* c. P-3.01, ss. 4, 5, 7: Healthcare providers and regional health authorities must report incidents in accordance with regulations. No provisions stated for persons outside defined group to report incidents. |
| NT (2016) | *Hospital Insurance and Health and Social Services Administration Act*, ss. 25.2.1: Critical incidents may be reported by any of the following persons: a patient or client, a relative of the patient or client; a person working for the Board of Management or territorial authority.  |
| **Element 3: Details on how an incident is reported** |
| BC (2013) | *Hospital Act* s 21(2): Reports must be made immediately and "in the form and manner specified by the minister." |
| SK (2004) | *The Provincial Health Authority Act*, ss. 8-2: Health service providers, provincial health authority and the cancer agency must report critical incidents. The procedures and timelines for reporting are located in Critical Incident Regulations, 2016. |
| MB (2005) | *Regional Health Authorities Act,* 53.2(2): Regional health authorities, health corporations and prescribed healthcare organisations must establish written procedures respecting providing information about and recording critical incidents as required in subsection (2), in accordance with guidelines approved by the minister. Timelines for reporting are not mentioned. |
| ON (2011) | *Hospital Management Regulation, ss. 2(4):* Provisions are made for hospital administrators to establish a system to ensure reporting of every critical incident as soon as possible to the medical advisory committee and administrator. The report to medical advisory committee and administrator must include material facts, description of cause(s) if known, consequences for patient, actions taken, and recommendations. |
| QC (2002) | *An Act Respecting Health Services and Social Services,* s. 233.I: Any person must report an incident or accident as soon as possible using a specific form that will also be placed in the patient record. |
| NB (2018) | *Health Quality and Patient Safety Act,* c. 21, ss 2-4: Healthcare organisations must report as soon as possible to their quality-of-care and safety of patients committee as well as the patient involved. If an incident that could have resulted in a patient safety incident occurs, the healthcare organisation has discretion to decide whether to notify the committee depending on ongoing safety risk. |
| NL (2017) | *Patient Safety Act*, c. P-3.01: Timelines and procedures not specified in detail in legislation, but provisions made for reporting to occur in accordance with regulations. To date, no regulations are in force. |
| NT (2016) | The *Hospital Insurance and Health and Social Services Administration Act* allows for regulations to set the details of critical incident reporting and disclosure, but no regulations are in force at this time. |
| **Element 4: To whom an incident is reported** |
| BC (2013) | *Hospital Act* ss. 21(2): Reports must be made to the minister. |
| SK (2004) | *The Provincial Health Authority Act*, ss. 8-2: Health service providers, provincial health authority and the cancer agency must report critical incidents. Individual health service providers report to provincial health authority, which reports to minister, investigates and reports again to minister. The provincial health authority must notify the minister and provide a copy of the report received from the health service provider(s). |
| MB (2005) | *Regional Health Authorities Act*, 53.2-53.3: Health corporations or prescribed healthcare organisations must report to regional health authority. The regional health authority must notify the minister. Critical Incidents Regulation: Designated organisations (e.g., Shared Health, CancerCare Manitoba) notify and report directly to the minister. |
| ON (2011) | *Hospital Management Regulation, ss. 2(4):* The hospital administrator must establish a system to ensure reporting of every critical incident as soon as possible to the medical advisory committee and administrator. |
| QC (2002) | *An Act Respecting Health Services and Social Services,* s. 233.I: Incident or accident reports must be made to the executive director of the institution or to a person designated by the executive director. |
| NB (2018) | *Health Quality and Patient Safety Act*, c. 21, 2-3: Healthcare organisations must report to their quality-of-care and safety of patients committee, which reports the incident and recommendations to the board of directors of the organisation. |
| NL (2017) | *Patient Safety Act*, c. P-3.01, ss. 4, 5, 7: The healthcare provider reports to the regional health authority and the regional health authority gives notice to the minister of adverse health events and occurrences that involve multiple patients or regions. |
| NT (2016) | *Hospital Insurance and Health and Social Services Administration Act*, ss. 25.2.1, 25.3: A patient or client or relative or a person working for the Board of Management or Territorial authority may notify the territorial board of management, the applicable board of management, or the minister. The territorial board of management, a board of management or other prescribed person shall inform the minister. |
| **Element 5: Provisions for confidentiality** |
| BC (2013) | No provisions found. |
| SK (2004) | Critical Incident Regulations, 2016, 6: Personal information would reasonably be expected to identify an individual to whom the critical incident relates or any healthcare provider or any other individual knowledgeable about the incident is protected.  |
| MB (2005) | *Regional Health Authorities Act* 53.6(2): A critical incident review committee must limit personal health information and personal information to the minimum amount necessary to properly carry out its duties. |
| ON (2011) | *Quality of Care Information Protection Act,* 9(8): A disclosure permitted under this section shall not contain more personal health information, as defined in the *Personal Health Information Protection Act*, 2004, than is reasonably necessary for the purpose of the disclosure. |
| QC (2002) | *An Act Respecting Health Services and Social Services,* s. 233.I*:* The executive director other designate will regularly report in a non-nominative form all incidents to the relevant agency. *s. 183.4:* Notwithstanding the *Act Respecting Access to Documents* held by public bodies and the protection of personal information (chapter A‐2.1), the records and minutes of a risk management committee are confidential. |
| NB (2018) | *Health Quality and Patient Safety Act*, c. 21, 6: The report of the quality-of-care and safety of patients committee must not contain personal information or personal health information. |
| NL (2017) | *Patient Safety Act*, c. P-3.01, s. 8-10: Personal information and personal health information are protected. The *Access to Information and Protection of Privacy Act, 2015* does not apply to the use, collection, disclosure, release, storage or disposition of, or any other dealing with, quality assurance information.*Personal Health Information Act*, c. P-7.01, s. 58(1)(cii.1): Information created or compiled for a patient safety incident report is protected. |
| NT (2016) | *Hospital Insurance and Health and Social Services Administration Act,* ss. 25.1(3): The minister may establish reporting and confidentiality requirements to support the work of quality assurance committees.*Evidence Act*, 15(3): Committees shall ensure the protection of confidentiality of any person whose treatment has been studied, evaluated, or investigated. |
| **Element 6: Protections in legal proceedings** |
| BC (2013) | *Evidence Act* s 51(2)*:* Information related to a proceeding before a committee or an investigation carried out by a committee is not permitted in legal proceedings. The only committee specified is the Critical Incident Report Sub-committee of the Quality Assurance Committee of the BC Anaesthetists' Society (Designation Regulation, BC Regulation 363/95). |
| SK (2004) | *The Provincial Health Authority Act,* ss*.* 8-2(6): Protects critical incident documentation from being shared in legal proceedings. |
| MB (2005) | *Manitoba Evidence Act,* 9(2)-(3): Critical incident information cannot be used in legal proceedings. Sec 9(4) excludes from protection the personal health information in records; the facts on what occurred; and certain other records. Disclosure of these records is provided for under *Regional Health Authorities Act.* |
| ON (2011) | *Quality of Care Information Protection Act*, 10(2): Quality-of-care information is not admissible in evidence in a proceeding. |
| QC (2002) | *An Act Respecting Health Services and Social Services*, s. 75, 183.3: No legal proceedings may be brought against a person exercising their functions including a service quality and complaints commissioner or other person acting under their authority. |
| NB (2018) | *Health Quality and Patient Safety Act*, c. 21, 7: Except on the trial of any person for an offence in respect of the person’s sworn testimony, no statement made, answer or evidence given by that or any other person in the course of any quality review by the quality of care and safety of patients committee is admissible in evidence against any person in any court or at any inquiry or in any other proceedings. |
| NL (2017) | *Evidence Act, s. 8.1:* A report of a close call or occurrence, or a notice to the minister of an adverse health event, shall not be disclosed in connection with a legal proceeding, and a person who appears as a witness in a legal proceeding shall not be asked to produce a report or notice. |
| NT (2016) | *Hospital Insurance and Health and Social Services Administration Act*, ss. 25.5(3-4): Information related to a critical incidents investigation are prohibited in legal proceedings. |
| **Element 7: Provisions for non-retaliation** |
| BC (2013) | Provisions to protect against suspension, harassment, demotion, or other retaliatory behaviour were not found. |
| SK (2004) | No provisions found. |
| MB (2005) | *Regional Health Authorities Act 53.9:* No person shall dismiss, suspend, demote, discipline, harass, or otherwise disadvantage another person because that other person has complied with a requirement to provide information, documents, or records. |
| ON (2011) | *Quality of Care Information Protection Act*, *11*: No one shall dismiss, suspend, demote, discipline, harass, or otherwise disadvantage a person by reason that the person has disclosed information to a quality-of-care committee under section 8. |
| QC (2002) | No provisions found. |
| NB (2018) | *Health Quality and Patient Safety Act*, c. 21, 5: No person shall dismiss, suspend, demote, discipline, harass, or otherwise disadvantage a person by reason that the latter has disclosed information to a healthcare organisation or a quality-of-care and safety of patients committee in connection with a patient safety incident or other incident. |
| NL (2017) | *Patient Safety Act*, c. P-3.01, ss. 11, 23: A person shall not dismiss, suspend, demote, harass, or otherwise disadvantage or penalise a health care provider who reported a close call or an occurrence. An action does not lie against individuals for releasing information to the minister or regional health authority in good faith for improving services. |
| NT (2016) | No provisions found. |
| **Element 8: Provisions for expert analysis** |
| BC (2013) | Reviewed legislation does not define whether incidents must be investigated by a committee or is investigated at all. |
| SK (2004) | *The Provincial Health Authority Act,* ss. 8-2(2): The provincial health authority has a duty to investigate any critical incident and provide a written report to the minister about the incident and investigation. The Critical Incident Regulations outline that the healthcare organisation and the provincial health authority have an obligation to act on critical incidents and report how they are addressing them. |
| MB (2005) | *Regional Health Authorities Act* 53.3(3): A critical incident review committee must investigate the critical incident. |
| ON (2011) | Hospital Management Regulation, ss. 2(5.1): The hospital administrator must establish a system to ensure each incident is analysed and a plan is developed with steps to avoid or reduce the risk of further similar incidents. *Excellent Care for All Act,* 3(1): Every healthcare organisation shall establish and maintain a quality committee. As per the *Quality of Care Information Protection Act*, 2(1), the committee undertakes functions including reviews of critical incidents. |
| QC (2002) | An *Act Respecting Health Services and Social Services*, s. 183.1, 183.2: The institution must create a risk management committee, among whose tasks is to identify and analyse risk of incidents or accidents in order to ensure the safety of patients, prevent such risks, and reduce their recurrence. |
| NB (2018) | *Health Quality and Patient Safety Act*, c. 21, 2: Each healthcare organisation (including regional authorities) is required to establish a quality-of-care and safety of patients committee. Quality-of-care and safety of patients committee must investigate and make recommendations following an incident. |
| NL (2017) | *Patient Safety Act*, c. P-3.01, ss. 2, 12, 13: Every regional health authority shall establish and maintain a quality assurance committee whose purpose is to study, review, investigate, assess, or evaluate the provision of health services (including close calls and occurrences), either ongoing or case specific, in order to make recommendations to improve. |
| NT (2016) | *Hospital Insurance and Health and Social Services Administration Act*, ss. 25.3(2,3): Designated healthcare bodies or the minister must appoint or assign a person or committee to investigate to (a) review whether or not a critical incident occurred; (b) review factors that may have caused or contributed to a critical incident; and (c) prevent the occurrence of critical incidents in the future. |
| **Element 9: Mandated incidents register** |
| BC (2013) | No provisions found. |
| SK (2004) | No provisions found. |
| MB (2005) | No provisions found. |
| ON (2011) | Hospital Management Regulation, ss. 2(5.2): Hospital administrator must provide aggregate critical incident data to hospital's quality committee twice a year (minimum). However, these provisions are limited to individual hospitals and no provisions are made for a provincial incidents register. |
| QC (2002) | *An Act Respecting Health Services and Social Services, 183.2, 431(6.2)*: The risk management committee must establish a monitoring system including a local register of incidents. The minister maintains a provincial register of incidents and accidents in order to monitor and analyse causes, ensure measures are taken to prevent recurrence, and ensure control measures are implemented as appropriate. |
| NB (2018) | No provisions found. |
| NL (2017) | *Patient Safety Act*, c. P-3.01, ss. 16: A regional health authority shall develop and implement a patient safety plan in the form and manner prescribed in the regulations when requested by the minister. However, no provisions found mandating an incidents register. |
| NT (2016) | *Hospital Insurance and Health and Social Services Administration Act*, ss. 25.1: Quality assurance committees conduct planned or systematic activities for the purpose of studying, reviewing, investigating, assessing, or evaluating the provision of health services or social services, either ongoing or case-specific and with a view to improving services. However, no provisions found mandating an incidents register. |
| **Element 10: Mandated annual review** |
| BC (2013) | No provisions found. |
| SK (2004) | No provisions found. |
| MB (2005) | No provisions found. |
| ON (2011) | *Excellent Care for All Act*, 8*:* Every year, every healthcare organisation must develop a quality improvement plan that includes performance improvement targets. In the case of public hospitals, the quality improvement plan must be based on aggregate critical incident data. Quality improvement plans are submitted to the Ontario Health Quality Council. |
| QC (2002) | *An Act Respecting Health Services and Social Services*, s. 33, 183.2, 431(6.2): The local service quality and complaints commissioner prepares an annual summary of activities and complaints received, but not of quality improvement activities. The risk management committee identifies and analyses the risk of incidents or accidents and maintains a local register. The minister maintains a provincial register of incidents and accidents in order to monitor and analyse causes, ensure measures are taken to prevent recurrence, and ensure control measures are implemented as appropriate. However, the timing of any regular reviews is not mentioned. |
| NB (2018) | *Health Quality and Patient Safety Act*, c. 21: The committee's report and recommendations are intended to support improving care and prevent occurrence of similar incidents. However, no provisions were found |
| NL (2017) | *Patient Safety Act*, c. P-3.01, ss. 16, 20: A regional health authority shall develop and implement a patient safety plan in the form and manner prescribed in the regulations when requested by the minister. The patient safety and quality advisory committee must report annually to the minister on its activities. However, the committee's legislated activities (ss. 2) focus on making recommendations rather than implementing or evaluating quality improvement recommendations. |
| NT (2016) | No provisions found. |

1Similar to WHO ‘harmful incident’; 2 Similar to WHO ‘patient safety incident’