CANADIAN INCIDENT ANALYSIS FRAMEWORK

Sample Analysis Team Charter

© 2012 Canadian Patient Safety Institute
All rights reserved. Permission is hereby granted to redistribute this document, in whole or part, for educational, non-commercial purposes providing that the content is not altered and that the Canadian Patient Safety Institute is appropriately credited for the work, and that it be made clear that the Canadian Patient Safety Institute does not endorse the redistribution. Written permission from the Canadian Patient Safety Institute is required for all other uses, including commercial use of illustrations.

Full Citation:
Incident Analysis Collaborating Parties. Canadian Incident Analysis Framework. Edmonton, AB: Canadian Patient Safety Institute; 2012. Incident Analysis Collaborating Parties are Canadian Patient Safety Institute (CPSI), Institute for Safe Medication Practices Canada, Saskatchewan Health, Patients for Patient Safety Canada (a patient-led program of CPSI), Paula Beard, Carolyn E. Hoffman and Micheline Ste-Marie.

This publication is available as a free download at: **www.patientsafetyinstitute.ca**

For additional information or to provide feedback please contact **analysis@cpsi-icsp.ca**

D. SAMPLE ANALYSIS TEAM CHARTER

Date
From:
Subj: Analysis Team Charter Memo
To:

1. This memo confirms that an Analysis Team will be convened to determine the contributing factors for the patient safety incident analysis briefly described below.

____

____

Date Incident Occurred ___/___/___ Date Organization was Aware of Incident ___/___/___
The analysis method is (check one): Comprehensive____ Concise ____ Multi-Incident ___

2. As part of the process, the team will be responsible for developing a final report and recommendations based on their expert analysis. All analyses are quality assurance, focused processes, and the team's products (e.g. interviews, preliminary and final reports, etc.) are considered confidential, privileged and protected under XYZ Act.

Note: If in the course of conducting the analysis it appears that the patient safety incident(s) under consideration may have been related to an intentional unsafe act or acts, the appropriate organizational representative will be contacted to determine if an administrative review, or other type of review process, should occur. See *Section 3.2* *for additional information.*

3. List of disciplines and/or services anticipated to be involved in this analysis:

____

____

____

____

4. List of potential internal (e.g. facility) and external experts or consultants:

____

____

____

____

5. Resources available to the team (e.g. room number, flip charts, laptop computer, etc.)

____

____

6. The team's final report is due on: ___/___/___

(Adapted from the Veterans Affairs National Center for Patient Safety, in the Canadian Root Cause Analysis Framework)[7]