



## CANADIAN INCIDENT ANALYSIS FRAMEWORK

### *Incident Analysis as Part of Incident Management*

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### *When to use the Framework*

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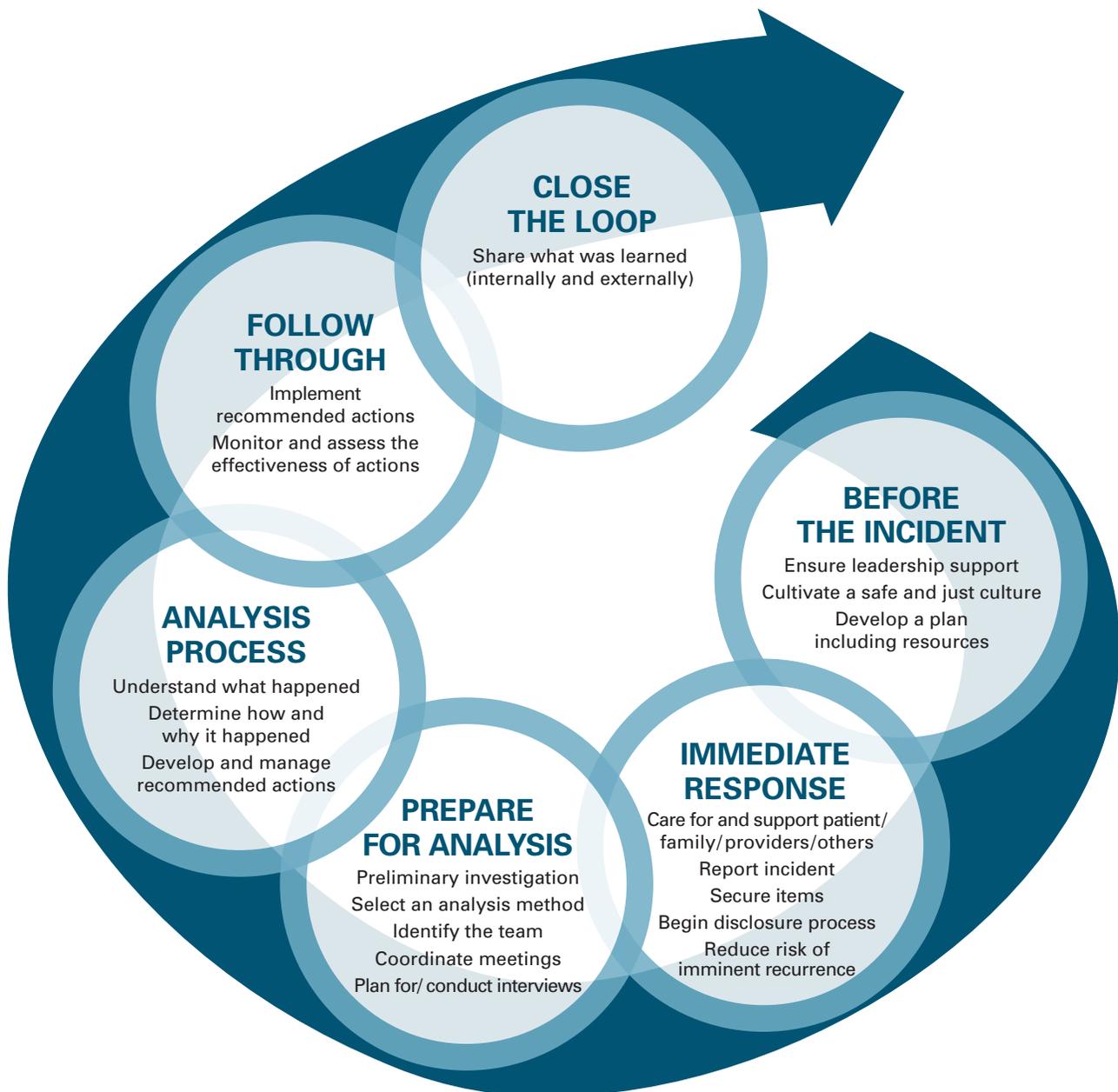
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# THE INCIDENT ANALYSIS FRAMEWORK

## 3.1 INCIDENT ANALYSIS AS PART OF INCIDENT MANAGEMENT

The purpose of this framework is to help those responsible for or involved in analyzing, managing and/or learning from patient safety incidents determine what happened; how and why it happened; what can be done to reduce the risk of recurrence and make care safer; and what was learned. In order to increase the effectiveness of analysis in improving care, incident analysis cannot be addressed in isolation from the multitude of activities that take place in the aftermath of an incident (incident management). The diagram below describes how analysis is an integral part of the incident management process. While there will be some variation in how healthcare organizations manage patient safety incidents, the basic steps will be consistent. There is interconnectivity and interdependence between the identified activities and some may take place simultaneously.

**Figure 3.1: INCIDENT ANALYSIS AS PART OF THE INCIDENT MANAGEMENT CONTINUUM**



Depending on the nature of the incident, these activities may be performed or conducted by a few individuals or a larger team who is assigned this responsibility (*Appendix C*). In some cases there may be different teams engaged at different times (e.g. there are different teams/members for disclosure, analysis and implementation).

As discussed earlier, the successful management of a patient safety incident is built on the principles of patient-centred care, safe and just culture, consistency and fairness, team approach and confidentiality (*Section 2.1*).

“LEARNING FROM EXPERIENCE CAN PREVENT HARMFUL MISTAKES FROM REOCCURRING. SAFETY IS ENHANCED BY LEARNING FROM FAILURE”.<sup>41</sup>

### 3.2 WHEN TO USE THE FRAMEWORK

This framework is not appropriate for all types of analyses.

The following types of incidents are **not recommended** for a system-based analysis:

1. Events thought to be the result of a criminal act;
2. Purposefully unsafe acts (an act where care providers intend to cause harm by their actions);
3. Acts related to substance abuse by provider/staff; and
4. Events involving suspected patient abuse of any kind.<sup>37</sup>

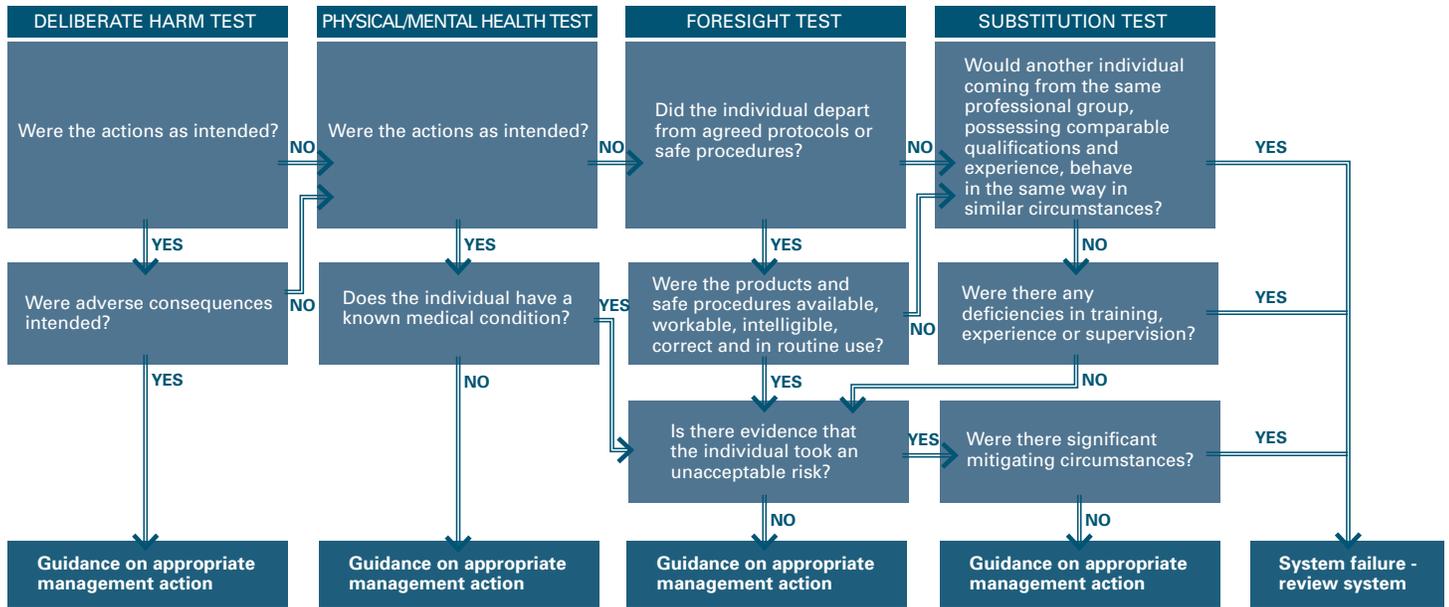
While these situations may provide examples for other system-based learning, as the content and subject matter directly relates to human resource processes (including individual performance management) and/or security systems, these situations require immediate referral to suitable administrative bodies and, where appropriate, to professional regulatory bodies for resolution.

It is important to protect the integrity of the incident analysis process from a situation where there is potential for dismissal, disciplinary action or criminal charges. In circumstances where disciplinary or other administrative action has been taken, it is still possible to run a parallel system-based incident analysis. However, it is imperative that information not be shared from one process to the other and that all participants are aware of the distinction between the two. When the parallel investigations are complete, the learning generated from each process can be valuable for improvement.

In most organizations, two types of formal reviews are generally available for unexpected clinical outcomes and patient safety incidents: system improvement reviews (often called quality reviews) and accountability reviews (also called proficiency reviews). This framework is focused on system improvement, whereas accountability reviews are directed to individual performance. Coaching and mentoring are preferred outcome actions when reviewing individual performance, unless the duty to avoid causing unjustifiable risk or harm has been breached. During the course of a system improvement review, concerns about individual performance may surface; an appropriate accountability review should be set up as a separate process to deal with the identified issues. Likewise, information about system failures revealed during an accountability review should be referred to a system improvement review.

The incident decision tree (*Figure 3.2*) has been adapted by the National Patient Safety Agency in the United Kingdom<sup>42</sup> to help determine when a system-based incident analysis is appropriate. It is based on the culpability model developed by James Reason.<sup>24</sup> An electronic version of the decision tree that includes additional detail is available online.<sup>43</sup>

**Figure 3.2: THE INCIDENT DECISION TREE** <sup>43</sup>



The Canadian Medical Protective Association, in *Learning From Adverse Events: Fostering a Just Culture of Safety in Canadian Hospitals and Health Care Institutions*<sup>40</sup> presents a different approach for determining when a system review or accountability review is appropriate and describes each type of review in detail. After collecting the facts and deciding if an analysis should be completed, the appropriate type of review can be determined by asking the following triage questions:

- Is it alleged there is a deliberate violation of sound policy by an individual provider?
- Is there a concern about the health of the provider?
- Is the dominant concern in this case about the clear lack of knowledge or skills, or significant unprofessional conduct by an individual provider?

If the answers to all of these questions are NO, a system improvement review should be launched and led by the quality improvement committee or subcommittee(s), with the focus on system (context of care) failures. If the answers to ANY of the above questions is YES, then an accountability review of individual providers should follow, led by leadership/management, with the focus on the performance of individual providers.

Occasionally providers will indicate that there is no need to analyze an incident because they believe that the harm resulted from a known complication. It is important to understand that with advances in care some complications will, over time, become preventable and, therefore, classified as patient safety incidents. Furthermore, patient safety incidents can be coupled with complications and, without conducting an incident analysis, opportunities for learning and improvement may be lost.