Canadian Framework for Managing Patient Safety Incidents

A tool to recognize, respond and reduce factors contributing to patient safety incidents

Canadian Patient Safety Institute
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Institute for Safe Medication Practices Canada
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Thank you:

Thank you patients, families, providers, regulators and funders for your passion and commitment to improving the safety of patient care. We invite you to share your successes and challenges on this journey.

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For additional information please contact IncidentManagement@cpsi-icsp.ca
Appendix A Canadian Framework for Managing Patient Safety Incidents (CPSI)

Incident Analysis Guiding Questions

A set of guiding questions is provided below as examples (not an exhaustive list) of questions to guide the identification of contributing factors during incident analysis. The questions are grouped around the eight categories of factors proposed in this Framework.

A. Task factors:
- Was a protocol available?
- Were test results available to make care decisions?
- What was the level of skill required to perform the task?
- Were there any time constraints?
- What was the chance of failure?
- Was a fixed sequence essential?
- Other

B. Equipment factors:
- Were the displays and controls understandable?
- Does the equipment detect and display problems? Is the maintenance/upgrade up to date?
- Is equipment located in the appropriate place and is it accessible?
- Is the equipment standardized or made of several different modules?
- Are the warnings/labels understandable?
- Is the safety mechanism functional and appropriate?
- Was enough training provided for this equipment?
- Other

C. Organization factors:
   Policies and procedures:
   - Is there a standardized process (order set/checklist)? Is it up to date?
   - Is the standard/policy available and workable?
   - Was training/orientation provided?
   - Do people work around official policy? Is there a feedback mechanism for staff when policy and practice don’t match?
   - Is there a risk assessment/audit/quality control program in place for the process?
   - Other

   Environment:
   - Do noise levels interfere with voice alarms?
   - Is the available lighting adequate for the task(s)?
   - Is the area adequate for people and equipment?
   - Is there clutter or inadequate storage?
   - Other

   Information systems
   - A. Is patient identification, documentation, available to all and up to date?
   - B. What is the level of automation? Was training provided?
   - C. Other

Scheduling and staffing levels
Were there any scheduling changes that influenced the staffing level or resulting in stress, fatigue?

D. Team factors:
- Is this a regular team? Are the roles defined? Are there authority gradients?
- What is the quality and quantity of communication between team members (verbal and/or written): i.e., clear, accurate, relevant, goal directed, sufficient, timely? Are there regular briefing, debriefings? Did the existing documentation provide a clear and comprehensive picture?
- How is the culture and morale? Was the communication between staff and management adequate? Was the communication between professions adequate, accurate, complete, free of jargon?
- Are communication systems (pager, phone) available and operational?
- Other

E. Caregiver factors:
- What is their position, education, experience, training?
- Was there fatigue, stressors, task saturation, overload, health, or other factors?
- What remunerations and/or other incentives (formal and informal) were in place?
- Did s/he seek help or supervision?
- Other

F. Patient factors:
- Consider the: age, sex, medications, allergies, diagnosis, other medical conditions
- Were there any social/ cultural factors involved? Was there a language barrier?
- Other

G. Other factors - consider
A. Are there any other local conditions or circumstances that may have influenced the outcome?
B. Are there any sector specific conditions or circumstances that may have influenced the outcome?