

# Integrating a Critical Incident Reporting Framework into your FHT

**Karen Hall-Barber, BSc(Hons), MSChQ (Candidate), MD, CCFP**  
Assistant Professor & Physician Lead, Queen's Family Health Team  
**Danyal Martin, BAH, BEd, MA, MSChQ (Candidate)**  
Clinical Program Coordinator, Queen's Family Health Team

## Disclosure Statement:

☑ We have no actual or potential conflict of interest in relation to this presentation\*\*

\*\*Except a passionate bias towards effectively promoting quality improvement in primary care



## A bit about us...

- Academic FHT
- Approximately 14,000 patients
- 5 clinical teams, 2 physical sites
- Academic interdisciplinary family medicine centre
- 50+ PGY1 residents & other learners
- 1.0 Data Analyst
- Inter-professional quality improvement committee, as well as various QI/safety related committees
- Open source EMR (OSCAR)

# Objectives:

1. Define key concepts related to patient safety
2. Make a case for the importance of critical incident reporting in primary care
3. Describe “just cultures” and how you can avoid “shame and blame” as you establish your critical incident reporting framework

# “TRIZ”

## Design

a critical incident reporting system  
that is that is guaranteed to *fail*

# Critical Incident Reporting Systems components that will make it **fail**

# Context



THE PUBLIC LIBRARY  
AS MODERN-DAY  
SALON

ARE YOU CLUELESS  
ABOUT MONEY?

IN CUBA,  
YOU ARE  
THE ONE PERCENT

# THE WALRUS

WALRUSMAGAZINE.COM • PUBLISHED BY THE WALRUS FOUNDATION

APRIL 2012

WHY  
24,000  
CANADIANS  
WILL DIE  
THIS YEAR

BECAUSE OF  
MEDICAL  
ERROR

BY RACHEL  
GIESE

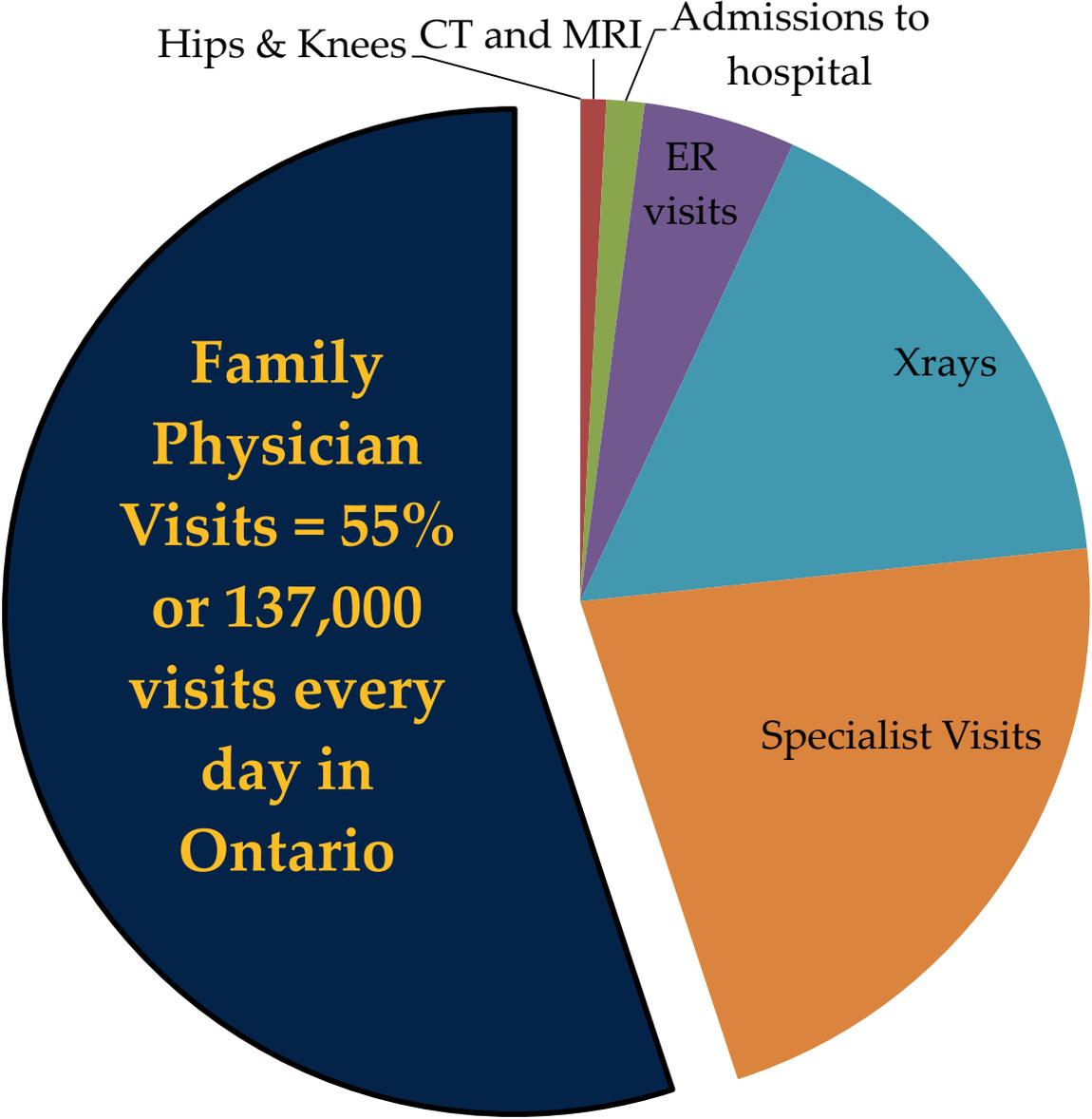
PLUS  
JENNIFER  
BAICHWAL,  
MARGARET  
ATWOOD,  
AND DEPT

Why  
does it  
matter?

Healthcare  
is not as safe as it  
should be

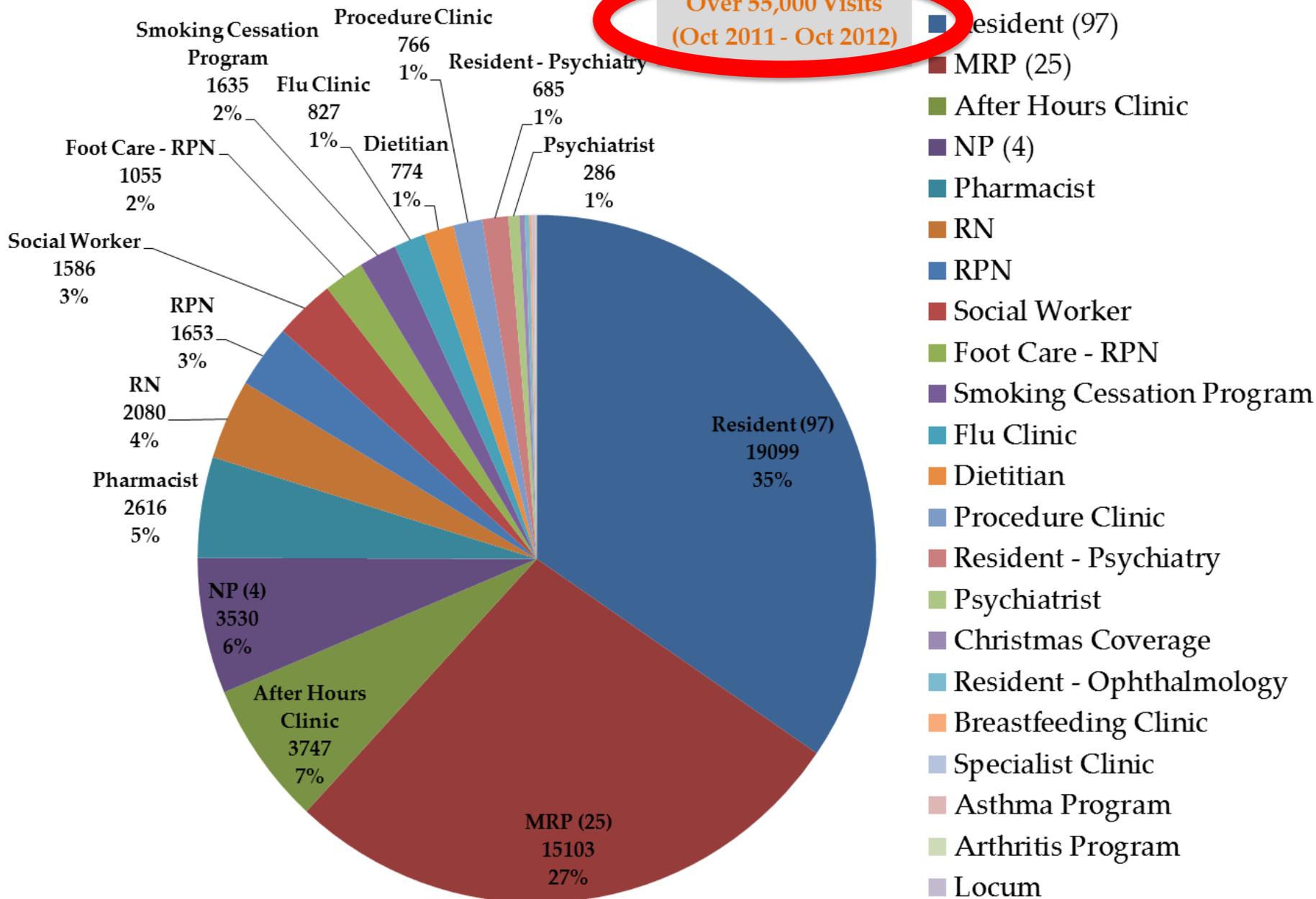
# Healthcare Encounters per day in Ontario

(Institute for Clinical Evaluative Studies 2003)



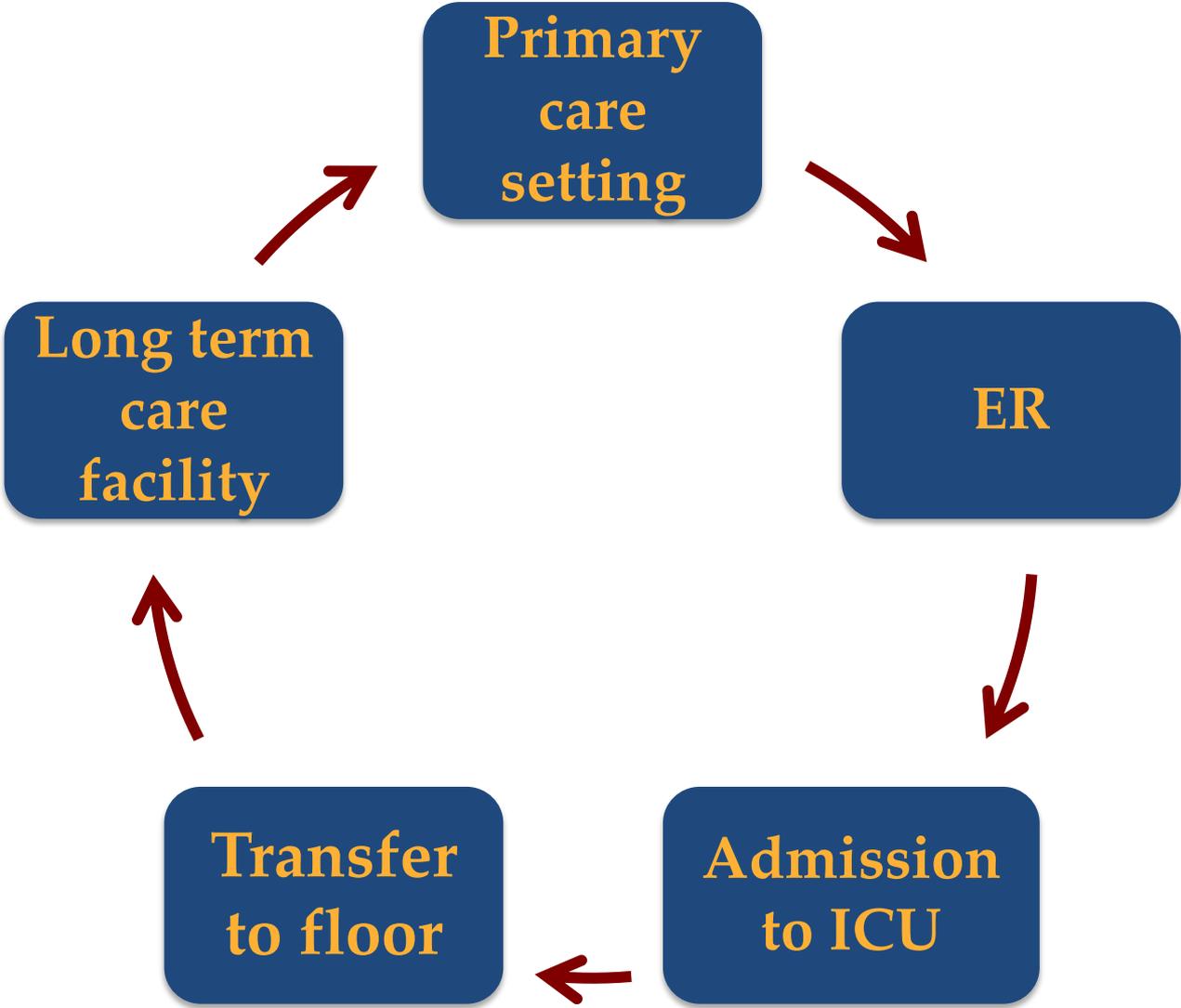
# Visits Last Year at Queens Family Health Team

Over 55,000 Visits  
(Oct 2011 - Oct 2012)

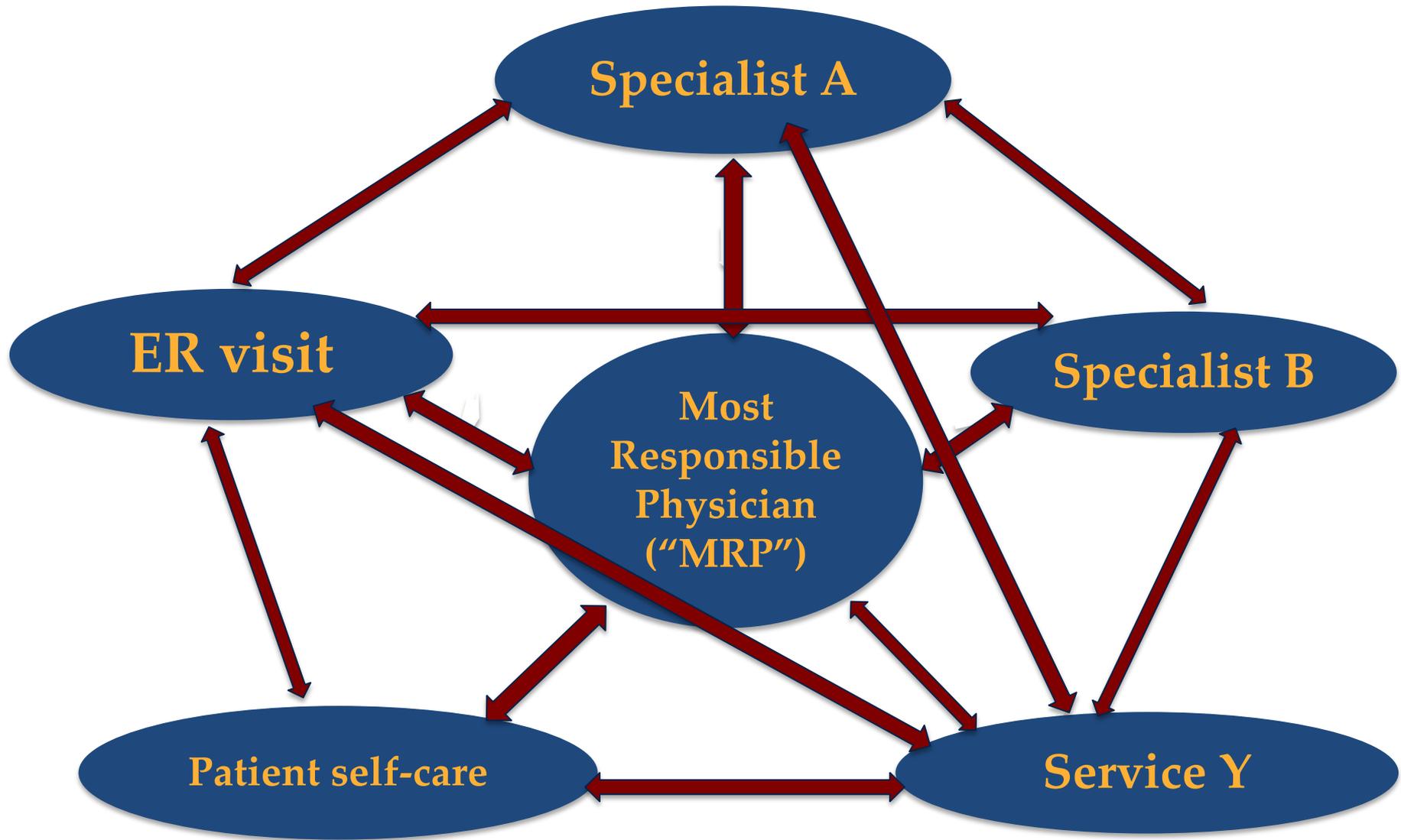


But there aren't  
patient safety issues in  
*primary care, right?*

# Sometimes a patient's journey looks like this:



But more often than not it looks like this:



# Transfer of patient care





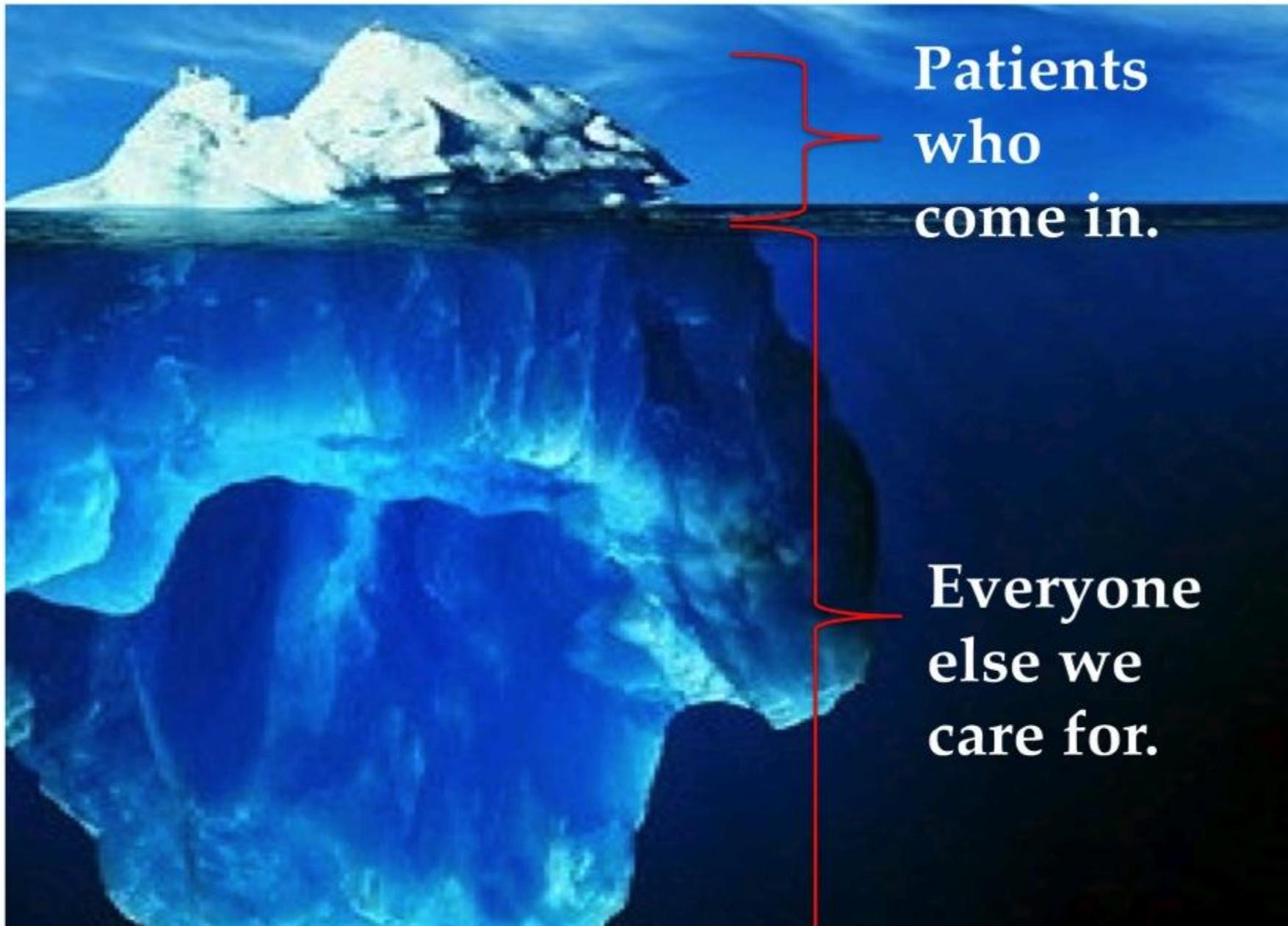


**Only 1 (out of 86!) medication list  
was accurate**



# For Want of a Nail...

For want of a nail the **shoe** was lost. For want of a shoe  
the **horse** was lost. For want of a horse the **rider** was  
lost. For want of a rider the **message** was lost.  
For want of a message the **battle** was lost.  
For want of a battle the **kingdom** was lost.  
And all for the want of a horseshoe **nail**.



Patients  
who  
come in.

Everyone  
else we  
care for.

Primary healthcare  
is not as safe as it  
should be

# Definitions & key concepts

What is patient safety?

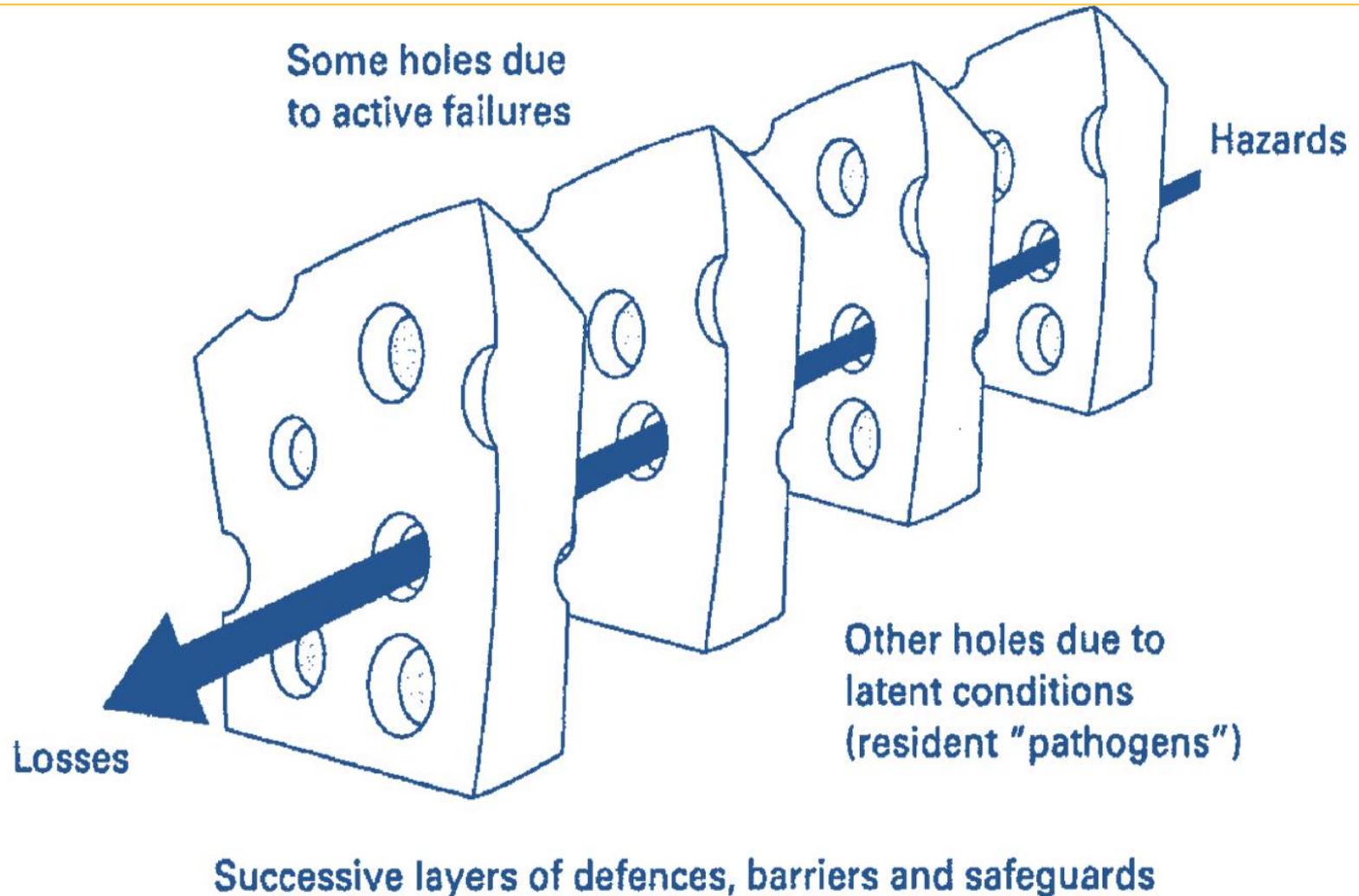
*The prevention of harm to patients* (IOM)

*Freedom from accidental or preventable  
injuries produced by medical care*

(AHRQ Patient Safety Network)



# The 'Swiss Cheese' Model of Causation





Efficiency Thoroughness Trade-Off  
(ETTO)

CAPTAIN SMITH AND OFFICERS S.S. TITANIC.  
Lost on 15th April, 1912, after collision with Iceberg in North Atlantic.

# Key Principles

- If someone knew their actions would have resulted in a failure, they wouldn't have done them.
- Actions are taken based on the information at hand.
- Accidents can be caused by both “active” failures and “latent” conditions

# What is an incident?

*An event or circumstance which could have resulted, or did result, in unnecessary harm to a patient.*

# What is an incident?



# Preventing errors







**Many process improvement ideas were discovered  
by mistake**

# How do you achieve it?

A system that is safe should:

- Prevent errors
- Learn from errors that do occur
- Build on a culture of safety that involves healthcare professionals, organizations, and patients

# Critical Incident

Allows one to capture:

- What happened?
- How and why it happened?
- What can be done to reduce the likelihood or recurrence and make care safer?
- What was learned?

From the Canadian Incident Analysis Framework, Canadian Patient Safety Institute

# Elements of Successful CI Reporting

- **Relevant** collection of information
- **Easy** to report
- **Transparent** processes
- **Non-punitive** approach - confidence that reporting will make a difference
- **Feedback** loop for prevention

# Critical Incident Reporting at QFHT





# Before the Incident

- Ensure leadership support
- Cultivate a safe and just culture
  - “Be preoccupied with failure”
- Develop a plan – Who will collect these incident? Who will review them?

From the Canadian Incident Analysis Framework, Canadian Patient Safety Institute

# Structural Elements

- Quality Assurance & Risk Management Committee
  - Physician Lead, ED, clerical & nursing managers, data analyst, IT, pharmacy
- Weekly management huddles and other support committees where safety is an agenda item
- Ad hoc safety meetings
- Reporting back via de-briefs and departmental meetings



Culture

Strategy

# Safe & Just Culture

- Patient safety requires that healthcare organizations build and maintain a safety culture.
- Safety culture is defined as “the product of individual and group values, attitudes, competencies, and patterns of behaviour that determine the commitment to and the style and proficiency of an organization's health and safety programs.”

# Safe & Just Culture

“Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventative measures.”

# Safe & Just Culture

Other characteristics:

- Openness, honesty, fairness, and accountability
- Requires and encourages the reporting of incidents and hazards
- Promotes safety training and preparedness
- Promotes the idea that improvement and prevention come from learning and understanding



*"This organization has a blame culture.  
And that's all Jeremy's fault."*

# Immediate Response

- Address the immediate needs of the incident. This may include caring for and supporting patients, disclosing the incident, and providing information.
  - It should also involve supporting the staff members involved.
- Report the incident.
- Take action to reduce risk of imminent recurrence.

From the Canadian Incident Analysis Framework, Canadian Patient Safety Institute



### INCIDENT REPORT

This form is to be used by any staff member or resident to report any unusual occurrence or incident as part of the Departmental Risk Management Program. NOT TO BE USED FOR MEDICATION ERRORS – use other form provided. Guidelines for completing this form are attached.

**ALL INCIDENTS RESULTING IN INJURY MUST BE REPORTED TO A MANAGER IMMEDIATELY. All other incident reports are to be submitted to a Manager within 1-2 working days of the incident**

Report initiated by (PRINT)	Position	Site

Date of Event	Time of Event	Site where event occurred/originated

**CATEGORY OF EVENT (check only the most applicable)**

<input type="checkbox"/> Aggressive/Disruptive Behavior	<input type="checkbox"/> Loss/damage to property
<input type="checkbox"/> Breach of confidentiality	<input type="checkbox"/> Procedure/process error
<input type="checkbox"/> Safety/health hazard	<input type="checkbox"/> Outside accident
<input type="checkbox"/> Documentation error	<input type="checkbox"/> Needle stick
<input type="checkbox"/> Elevator related	<input type="checkbox"/> Bodily injury
<input type="checkbox"/> Equipment failure	<input type="checkbox"/> Patient related critical incident (potential or real)
<input type="checkbox"/> Patient complaint/concern	<input type="checkbox"/> Fall (patient, staff, visitor, resident)

**DETAILS OF THE EVENT (completed for all incidents)**

Patient involved?  Yes  No  Unsure If Yes, provide name \_\_\_\_\_

Has event has been recorded in patient's health record  Yes  No Patient /family notified  Yes  No

Incident observed?  Yes  No  Not sure By whom: Name: (print)

Provide a brief and accurate account of the incident. DO NOT report conclusions or opinions, only fact.

Injury Sustained?  Yes  No  Don't know

Tick off location of injury:  Head  Back  Right arm/hand  Right leg/foot  
 Neck  Torso  Left arm/hand  Left leg/foot

**If Yes, indicate degree of injury**

- Slight, first aid, no medical intervention
- Moderate – medical assessment with mild intervention required
- Serious- significant medical intervention required

Status of person injured:  Patient  Staff  Resident  Visitor

Persons notified of the incident

Name (s)	Date	Time
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature of Reporter: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION BELOW COMPLETED BY MANAGERS/RISK COORDINATOR**

**Investigation/Recommendations (to be completed by Manager)**  Issue Resolved  Issue Not Resolved

**Contributing Factors:**

- Insufficient training
- Unsafe equipment
- Unsafe practice
- Weather
- Hazardous environment
- Failure to use personal protective equipment

**Corrective measures/actions to prevent recurrence (check all that apply)**

- Reinstruction of person involved
- Reassignment of person involved
- Ergonomic assessment
- Installation of guard or safety device
- Action to improve work procedure
- Manufacturer notified
- Improve personal protective equipment
- Equipment repair or replacement
- Correction of congested area
- Discipline of persons involved

Other: \_\_\_\_\_

Signature of Manager: \_\_\_\_\_ Date: \_\_\_\_\_

**ACTION TAKEN/RECOMMENDATION FOR ACTION PLAN**

Summarize action taken or action plan to correct problem:

OUTCOME:

SIGNATURES: Direct Manager \_\_\_\_\_ Risk Coordinator \_\_\_\_\_

(forward where appropriate to Head of Department)



**DEPARTMENT OF FAMILY MEDICINE/QFHT  
MEDICATION INCIDENT REPORT FORM**

Date of Incident: \_\_\_\_\_ Time: \_\_\_\_\_  
 Date of Discovery \_\_\_\_\_ Time: \_\_\_\_\_

<b>NATURE OF INCIDENT (Check one)</b> <input type="checkbox"/> Narcotic Incident <input type="checkbox"/> Prescribing Incident <input type="checkbox"/> Dispensing Incident <input type="checkbox"/> Documentation Incident <input type="checkbox"/> Administration of Medication
---

<b>MEDICATION INCIDENT (No patient involved)</b> <input type="checkbox"/> Unordered drug <input type="checkbox"/> Incorrect preparation <input type="checkbox"/> Other	<b>MEDICATION ERROR (patient involved)</b> <input type="checkbox"/> Event noted on health record <input type="checkbox"/> Incorrect patient <input type="checkbox"/> Omitted Dose <input type="checkbox"/> Incorrect dose <input type="checkbox"/> <input type="checkbox"/> Incorrect medication <input type="checkbox"/> Failure to note allergy <input type="checkbox"/> Incorrect route <input type="checkbox"/> Other (specify) _____
<b>MEDICATION(S) INVOLVED (print)</b>	<b>ROUTE ADMINISTERED (print)</b>

**Please indicate number of dose received or omitted in error:**

**Professional status of person involved:**  
**Was the error perpetuated by another practitioner: (if yes, explain below)**

<b>FACTS OF THE INCIDENT (no opinions/conclusions)</b>	<b>PATIENT OUTCOME</b> <input type="checkbox"/> Minimal/No clinical significance <input type="checkbox"/> Moderate (required medical assessment, adjustment in orders) <input type="checkbox"/> Serious (required immediate medical intervention)
--	--

<b>PERSONS NOTIFIED (as applicable)</b> <input type="checkbox"/> Nurse Manager <input type="checkbox"/> Pharmacist <input type="checkbox"/> Resident <input type="checkbox"/> Physician <input type="checkbox"/> Patient/family <input type="checkbox"/> Clinic Manager
---

<b>CONTRIBUTING FACTORS (check only most appropriate)</b> <input type="checkbox"/> Failure to notice order <input type="checkbox"/> Order not sent to pharmacy <input type="checkbox"/> Error in patient ID <input type="checkbox"/> Error calculating dose <input type="checkbox"/> Incorrect/unclear order <input type="checkbox"/> Misread/Interpreted order <input type="checkbox"/> Miscommunication <input type="checkbox"/> Transcription Error <input type="checkbox"/> Incorrect drug/dose from pharmacy <input type="checkbox"/> Failure to check chart/EMR <input type="checkbox"/> Other _____
--



# Analysis

- Understand what happened
- Determine how and why it happened
- Develop and manage recommended actions
- Be timely, interdisciplinary, objective, and supportive

## Be careful of cognitive traps!

“If I were given one hour to save the planet, I would spend 59 minutes defining the problem and one minute resolving it.”

Albert Einstein

# Follow Through

- Implement recommended actions
- Monitor and assess the effectiveness of actions
  - This will be harder than it seems!

# Framework of QFHT Clinical Quality



Queen's  
UNIVERSITY

EFFICIENCY EFFECTIVENESS

SAFETY

TIMELINESS

EQUITY

PATIENT CENTREDNESS

# Case 2:

## Treatment prescribed for the wrong patient



Queen's  
UNIVERSITY

### HOME CARDIOGRAPHICS

C/O HOTEL DIEU HOSPITAL, JM3  
166 BROCK STREET  
KINGSTON, ONTARIO K7L 5G2

## Event Recorder Report

Current Date: 24-Jan-2011

ECG Date and Time: 21/01/2011 1:37:29 PM

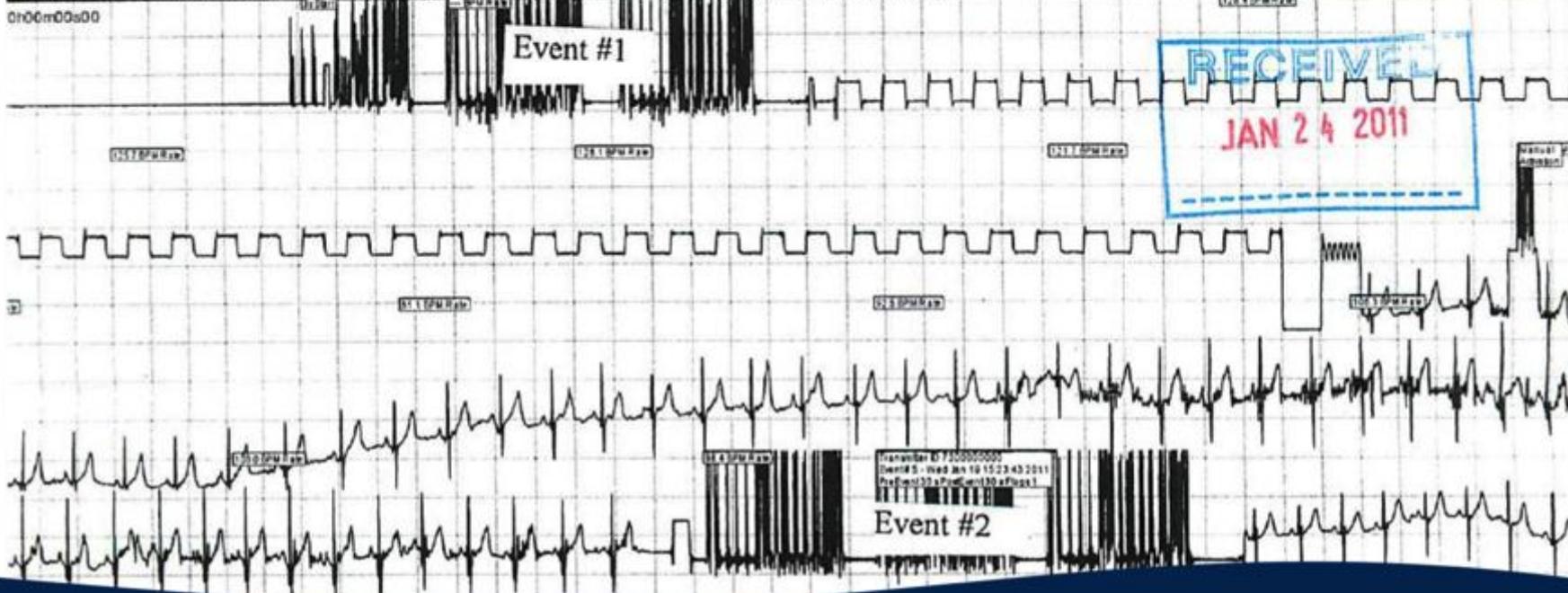


Holter Monitors, ECGs  
and Event Recorders

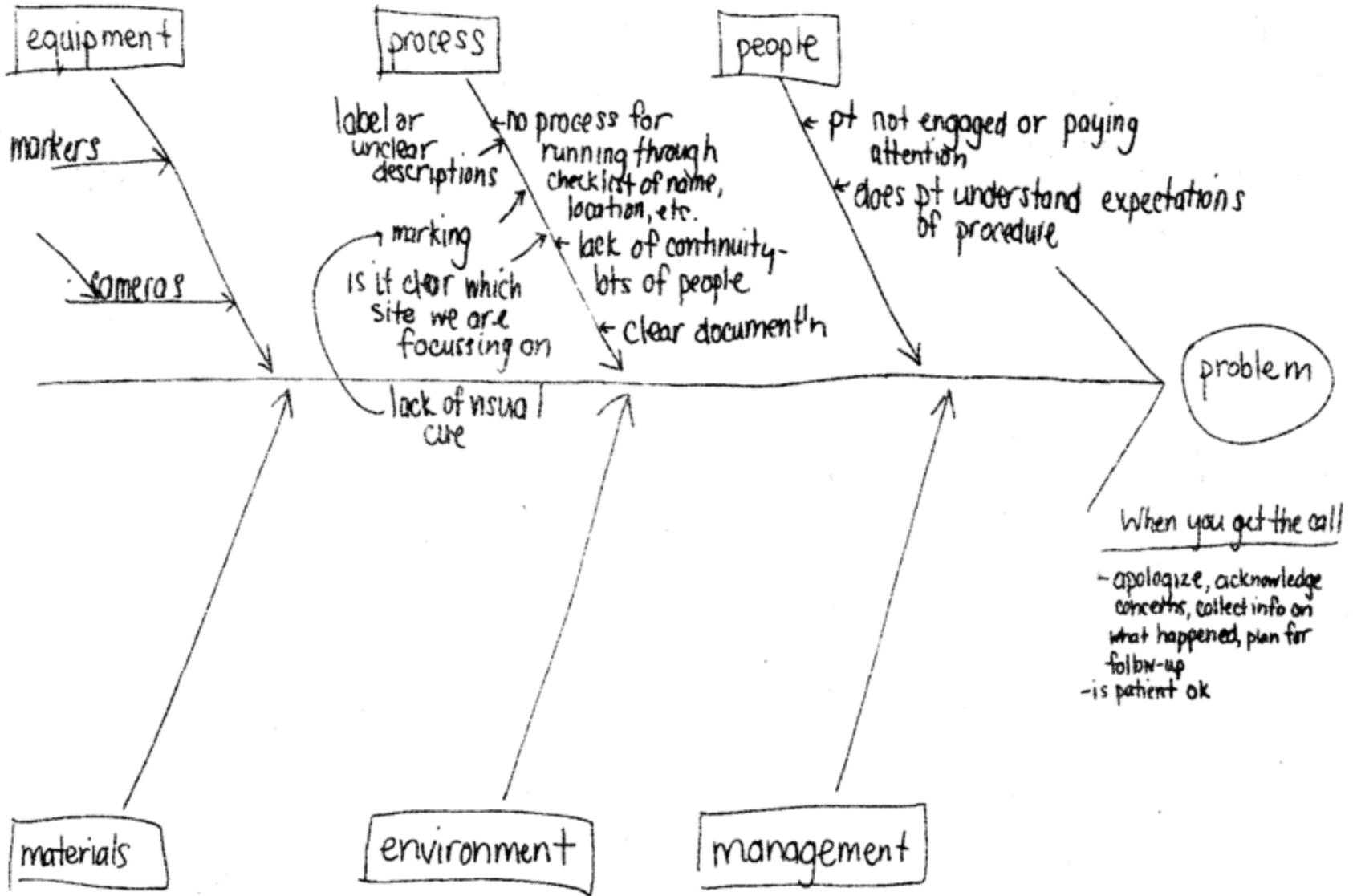
**Patient:** Johnny  
**Birth Date:** ~~born~~ /2001/(10)  
**Facility:** Home Cardiographics (HDH)  
**Symptoms:** Fluttery, feels weird

**Health Card #:**  
**Family Dr.:**  
**Specialist:** Moore, Dr. A

Full Disclosure 21/01/2011 1:37:29 PM(M) Speed:10 mm/s Gain:5 mm/mV High Pass Filter:none Low Pass Filter:none



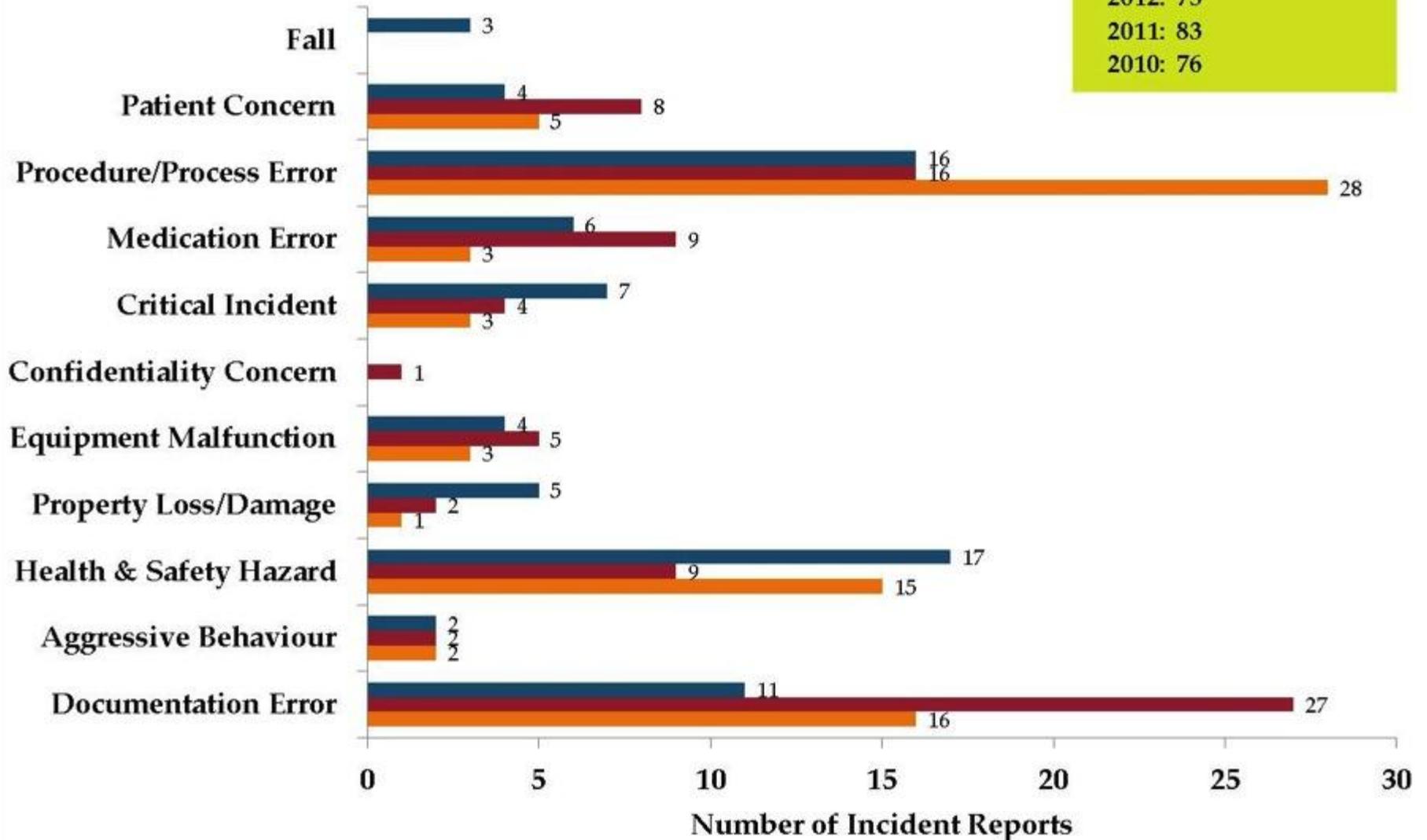
# Close the Loop



# QFHT Incident Reports 2010 - 2012

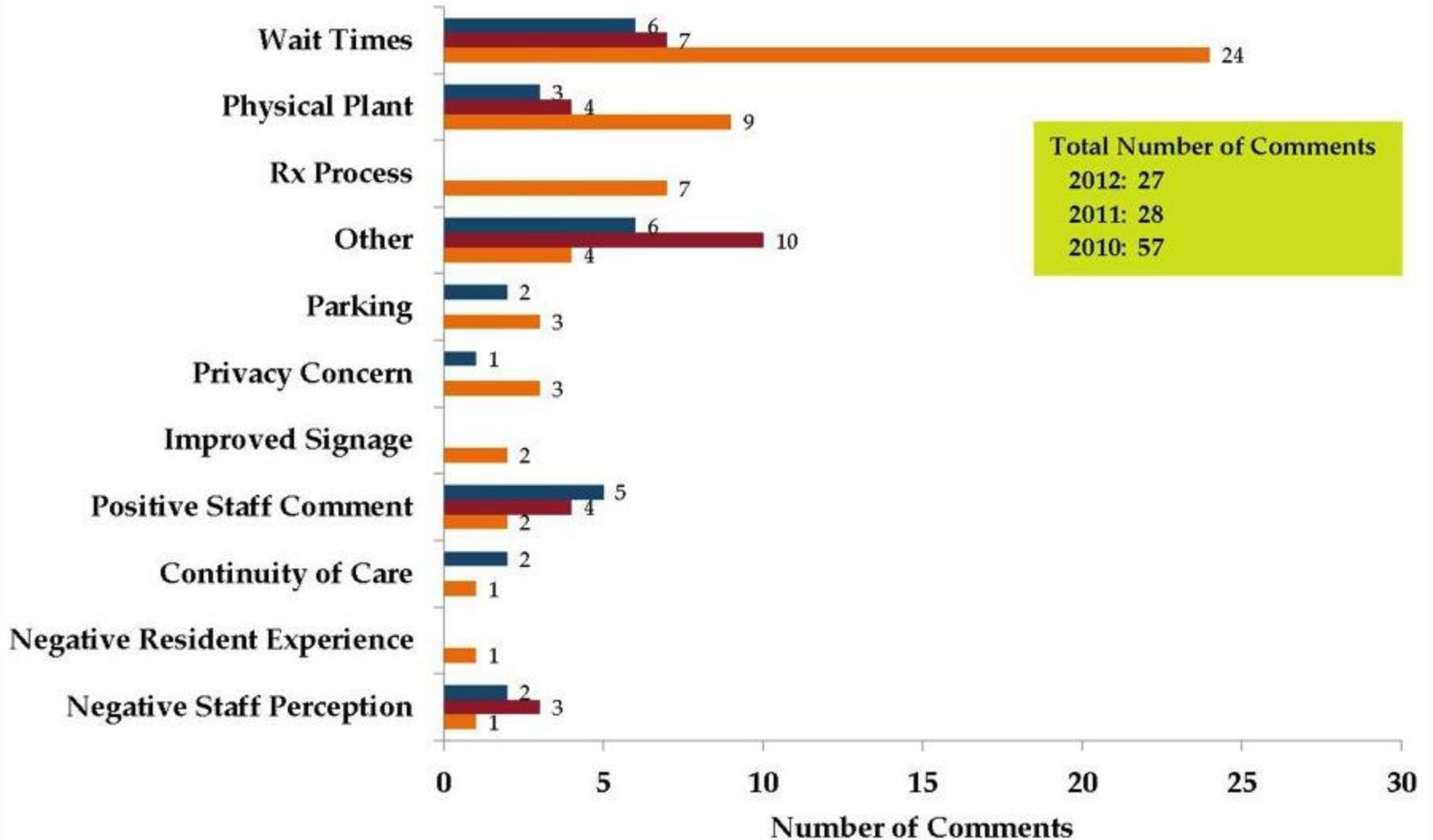
■ 2012 ■ 2011 ■ 2010

**Total Number of Reports**  
2012: 75  
2011: 83  
2010: 76



# QFHT Suggestion Box Comments 2010 - 2012

■ 2012 ■ 2011 ■ 2010



**A few final words**







# Report Near Misses



Checking a **near** thing can  
prevent the **real** thing!

Emily  
1808,  
North Da-  
of kaolinite  
mineralogist  
1874-1954,

mining immunity or  
ch scarlet fever toxin  
being character-  
[1920-25; named

th-east dictey.  
dickey.  
(-), adj. Bot  
having the stamens and the  
either on the same plant or on  
erous or dioecious. 2 (of a  
or only pistils; unisexual.  
ch, bed + -ous) —di/ck-

white crystalline solid,  
ed to protect crops  
Explained orig.]  
Also, di-cot-yl

dic-tion (dik-shən)  
as dependent upon  
accent, inflection,  
terms of prevailing usage  
tion. [1400; by late ME  
said, spoken (sep. of diverse)  
word, L. theoretic]

—Syn. 1. usage  
wording refer to the meaning. Dic-  
ing ideas. Diction usually implies a  
it refers chiefly to the choice of  
ment, and the force, accuracy, and  
they are used. The speaker or  
cellent diction; poetic diction; and  
to the manner of combining the  
groups, and esp. to the peculiar  
which certain technical, scientific,  
are expressed. legal phraseology  
exact words or phraseology used  
wording of a will.

1. (of a  
and the  
plant or on  
2 (of a  
unisex-  
di/ck-

white crystalline solid,  
ed to protect crops  
Explained orig.]  
Also, di-cot-yl

dic-tion-ar-y (dik-shə-ner-ē), n., pl. -aries. 1. a book  
containing a selection of the words of a language, usually  
arranged alphabetically, giving information about their  
meanings, pronunciations, etymologies, inflected forms,  
etc.; expressed in either the same or another language;  
lexicon; glossary: a dictionary of English; a Japanese  
English dictionary. 2. a book giving information on  
particular subjects or on a particular class of words;  
names, or facts, usually arranged alphabetically: a bio-  
graphical dictionary; a dictionary of mathematics.  
Computers. a. a list of codes, terms, keys, etc., and  
meanings, used by a computer program or system  
list of words used by a word-processing program  
standard against which to check the spelling of  
tered. [1520-30; < ML dictionarium +

1. (of a  
and the  
plant or on  
2 (of a  
unisex-  
di/ck-

white crystalline solid,  
ed to protect crops  
Explained orig.]  
Also, di-cot-yl

white crystalline solid,  
ed to protect crops  
Explained orig.]  
Also, di-cot-yl

Bot. any  
subclass)  
yledons  
mono-  
Lin-

white crystalline solid,  
ed to protect crops  
Explained orig.]  
Also, di-cot-yl

white crystalline solid,  
ed to protect crops  
Explained orig.]  
Also, di-cot-yl

white crystalline solid,  
ed to protect crops  
Explained orig.]  
Also, di-cot-yl

white crystalline solid,  
ed to protect crops  
Explained orig.]  
Also, di-cot-yl

white crystalline solid,  
ed to protect crops  
Explained orig.]  
Also, di-cot-yl

white crystalline solid,  
ed to protect crops  
Explained orig.]  
Also, di-cot-yl

white crystalline solid,  
ed to protect crops  
Explained orig.]  
Also, di-cot-yl

### Mayo Clinic Quality Academy Educational Resources



Why is Quality Improvement/Patient Safety Important in Health Professions Education?

00:00 / 02:13

Why is quality improvement/patient safety important in health professions education? - Terrence L. Cascino, MD, Executive Dean for Education, Mayo Clinic

Please login with your email address below. Your email address is used solely to remember your place when you return.

E-mail address \*

  
 Name  
  
 Institution Name \*
  
 Profession \*

- SELECT -

Login



safer healthcare  
*now!*



Come up with as many factors  
as you can that will guarantee  
that a critical incident  
reporting system will **succeed.**

# Questions or ideas?

Dr. Karen Hall Barber

[karen.hallbarber@dfm.queensu.ca](mailto:karen.hallbarber@dfm.queensu.ca)

Danyal Martin

[danyal.martin@dfm.queensu.ca](mailto:danyal.martin@dfm.queensu.ca)