

CRITICAL Incident Learning

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Distributed to:

- Chief executive officers
- Chiefs of staff
- Board chairs
- Quality/patient safety leads
- Directors of pharmacy

Suggested circulation:

- Hospital and organizational leadership
- Quality, risk, and patient safety personnel
- Clinical leadership
- Medical directors
- Medical advisory committees
- Hospital safety and quality committees
- Drugs and therapeutics committees
- Physicians, pharmacists, nurses, and other front-line staff

Mandatory Reporting—Can We Do Better?

Background

- To advance the patient safety agenda, in August 2011 the Ontario Ministry of Health and Long-Term Care (MOHLTC) issued a directive that hospitals must report critical incidents involving medications and intravenous (IV) fluids to the Canadian Institute for Health Information (CIHI) National System for Incident Reporting (NSIR).¹
- Anonymous data from the NSIR are analyzed by the Institute for Safe Medication Practices Canada (ISMP Canada) to identify medication system vulnerabilities, to share strategies for mitigating risks, and to inform medication safety efforts in Ontario.
- On the basis of these analyses, ISMP Canada will develop and disseminate outcome-directed recommendations, with an emphasis on high-leverage actions that take into account human factors engineering principles and the need to design systems with integrated safeguards.
- Accreditation Canada focuses a number of its Required Organizational Practices on medication safety. Reporting incidents through the NSIR supports Accreditation Canada's guidelines on adverse event reporting and client safety quarterly reports.²

Learning from Analysis

- In the first year of mandatory reporting, from October 1, 2011, to October 1, 2012, a total of 15 critical incidents were submitted, including 5 that resulted in death.^{3,4} This likely represents under-reporting of the true number of critical incidents.
- Many of the reports of critical incidents received through the NSIR did not include sufficient detail to allow for meaningful analysis or to allow sharing of quality improvement strategies.
- To date, the NSIR has an underutilized message system that could be used to solicit further details on a submitted report.

Call to Action for Hospitals

- Promote detailed reporting to the NSIR of all critical incidents within 30 days, including a detailed description that elaborates on specific circumstances and variables that led to the incident.
- Perform effective analysis of incidents from your facility to identify vulnerabilities in systems.
- Report any recommendations or strategies that you develop to the NSIR within 60 days.
- Ensure that your hospital NSIR administrator responds to emails from CIHI for ISMP Canada follow-up with your hospital.
- Use the learning from these analyses to improve systems and procedures related to patient safety.
- Share learning from your facility through ISMP Canada and other organizations, so that all patients, healthcare workers, and facilities can benefit.



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Discussion

The MOHLTC directive mandating that all critical incidents involving IV fluids and medications be reported to the NSIR builds upon the patient safety and quality initiatives of the *Excellent Care for All Act*⁵ and Regulation 965 under the *Public Hospitals Act*⁶. According to Regulation 965, a critical incident is an “unintended event that occurs when a patient receives treatment in the hospital that results in death, or serious disability, injury or harm, and does not result primarily from the patient’s underlying medical condition or from a known risk inherent in providing treatment”⁶.

ISMP Canada has been identified as the lead organization for analysis of the reported incidents. A multidisciplinary team reviews each submitted critical incident report to ensure effective identification of the contributing factors. In addition, ISMP Canada will periodically conduct aggregate analysis of reported incidents to provide a more in-depth assessment of events involving a particular medication or care setting.

Of the 15 critical incident reports submitted to date through the NSIR, 5 did not describe the incident and 9 did not mention any preventive activities planned or implemented within the organization or recommendations to minimize future harm. It is hoped that this aspect of reporting will improve, as comprehensive reporting through the NSIR, including detailed descriptions of the medication incident and actions taken at the hospital level, will support the MOHLTC focus on improving patient safety and will allow for sharing of recommendations.

Conclusion

Incident reporting is indicative of a culture committed to safety. A greater number of reported incidents does not always reflect severe problems; rather, it highlights an organization’s focus on and prioritization of patient safety. Hospital leadership is responsible for ensuring compliance with reporting requirements.

Results of the critical incident reporting program to date suggest that there are opportunities to improve both the quantity and the quality of reports submitted and that doing so would optimize program outcomes. In particular, achieving the desired outcomes will require greater stakeholder commitment to medication incident reporting and learning. Ontario hospitals and practitioners are encouraged to review their reporting processes to enhance participation in this important program.

Healthcare providers and organizations have acknowledged that sharing of analyses, safe practices, and innovative ideas are key to improving patient safety. Working together, we can decrease preventable harm associated with medication use in Ontario.

¹ ECFAA and a new directive on medication incidents/IV fluids. Toronto (ON): Ontario Ministry of Health and Long-Term Care; 2011 [cited 2012 Oct 11]. Available from: http://www.health.gov.on.ca/en/common/legislation/ecfa/updates/criticalincident/update_20110901.pdf

² Required organizational practices 2012. Ottawa (ON): Accreditation Canada; 2012 [cited 2012 Oct 11]. Available from: <http://www.accreditation.ca/uploadedFiles/ROP%20Handbook%20EN.pdf>

³ National System for Incident Reporting. Ottawa (ON): Canadian Institute for Health Information. Analysis generated on October 3, 2012.

⁴ Minimum data set. In: National System for Incident Reporting. Ottawa (ON): Canadian Institute for Health Information; 2012.

⁵ The Excellent Care for All Act, 2010. Toronto (ON): Ontario Ministry of Health and Long-Term Care; 2010 [cited 2012 Oct 11]. Available from: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_10e14_e.htm

⁶ The Public Hospitals Act, 1990. R.R.O. 1990, Regulation 965: Hospital management. Toronto (ON): Ontario Ministry of Health and Long-Term Care; 1990 [cited 2012 Oct 11]. Available from: http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_900965_e.htm#BK1

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Collaborating parties of the Ontario Critical Incident Reporting program

