RISK NOTE

Critical Incidents – Written Analysis Report

OVERVIEW OF ISSUE

When the analysis of the critical incident is complete, the review team will need to prepare a report summarizing the results. There is considerable variation in the size and scope of these reports.

The aim of this Risk Note is to provide guidance on writing the critical incident report.

KEY POINTS

- A critical incident report should include a short narrative of the event, key findings; recommendations for improvement; and a chronology of events.

THINGS TO CONSIDER

Report Elements

- The following elements should be included in the report:
  - A short narrative of the event;
  - Issues/key findings/contributing factors;
  - Recommendations for improvement;
  - Chronology of events (often as an appendix).
- The report may or may not include more detailed action planning related to recommendations implementation. Some organizations may have a process for hand-off of report recommendations, following a vetting and approval process by senior leaders, to risk management, quality improvement or project management staff for action planning and implementation support.
- Note: Thorough action planning (including identification of responsible individuals, resources required, project planning and expected dates of completion) may take some time to do effectively.

Report Confidentiality

- Review teams need to balance the need to provide enough evidence to support findings and recommendations with the risks that the report could be disclosed in a subsequent legal proceeding, thereby impacting the willingness of staff to participate in future reviews.
- Best practices for ensuring report confidentiality and quality assurance privilege include:
  - Ensure the rationale, expectations and obligations related to confidentiality are discussed with all review participants (does not apply to patient and family members);
  - Ensure reports are concise, factual and focused on systems-related improvements;
  - Write reports keeping in mind the (unlikely) possibility that it may be discovered in a legal proceeding;
  - Ensure reports do not contain any quotes, opinions, speculations made by participants, nor any reference to staff performance related matters;
  - Ensure reports do not contain language regarding breach of standard of care, or negligence as these are legal determinations;
  - Limit and carefully track the numbers of draft reports that are distributed among review team members and/or to key senior leaders; circulate paper-based versus electronic copies if possible;
  - Emphasize report confidentiality by including appropriate language in headers or footers (e.g. “privileged and confidential – for patient safety purposes only”);
  - Limit the number of final reports and keep them in a secure location (e.g. one kept in the Risk Management department);
  - Share report findings/recommendations with those that require the information to make improvements;
  - Ensure systemic steps taken (and planned to be taken) are disclosed to the patient/family and that documentation of the discussion is included in the risk management or patient relations file.

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REFERENCES

- Canadian Patient Safety Institute. (2011). Canadian disclosure guidelines: Being open with patients and families.
- Canadian Patient Safety Institute. (2012). Canadian incident analysis framework.
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- Laupacis A, Morin A. (2014). QCIPA review committee recommendations. Ontario Ministry of Health and Long-Term Care.
- Ontario Hospital Association. (2004). Quality of care information and protection act toolkit.