RISK
NOTE

Types of Incident Reviews

OVERVIEW OF ISSUE

Various types of reviews may be undertaken in response to an incident in healthcare. Reviews may be requested by various parties, e.g. senior management, clinical leaders or legal counsel. Systems reviews have different goals than do medical-legal reviews. The learnings from systems reviews should be shared, as appropriate, to reduce the risk of similar incidents in the future. This Risk Note describes three different types of incident reviews: systems, medical-legal, and practice/competency.

KEY POINTS

- The goal of a systems review is to generate recommendations for change whereas a medical-legal review is conducted in order to assess a healthcare provider's culpability.

THINGS TO CONSIDER

Systems review

- Premise is that patient safety events are the result of system errors.
- Objective is to assess what factors contributed to the event and to make recommendations for change.
- Reviewers look at what system factors contributed to the outcome (i.e. organization, work environment, equipment, care team, task, and patient).
- Approach is non-punitive, collaborative, and is a key feature of a 'just culture'.
- Review may be protected under quality of care legislation; this must be designated in writing prior to commencing the review, i.e. review mandated to be done under specific provincial quality review legislation by quality of care committee.
- Can take various forms, e.g. failure modes and effects analysis, root cause analysis, serious safety event analysis.
- Alternatively, a properly constituted review may be protected under common law quality assurance privilege. Refer to Privilege Risk Note.

Critical incident review (may be referred to as quality of care review)

- Also known as a systems review of an incident causing death, disability or serious injury to the patient.
- General steps include:
  - Ensuring initial and post-analysis disclosure to the patient/family has taken place;
  - Triggering the analysis with approval from leadership;
  - Identifying lead/team members, which may include patient representative;
  - Reviewing relevant documents (e.g. health record, policies), process review, and analyzing previously sequestered physical artefacts (if applicable);
  - Drafting an event timeline;
  - Obtaining feedback from those involved and additional expert opinion (if needed);
  - Identifying issues and contributing factors;
  - Developing recommendations for improvement;
  - Preparing a summary report for leadership review and approval.
- Following the review, implement and evaluate approved recommendations. Continue or modify changes implemented based on evaluation. Share lessons learned and trend overall results.
- May be conducted across organizations.
- Note: this approach can be scaled to analysis of less serious incidents.

Morbidity and mortality rounds

- Also known as a systems review examining the care of an individual patient; incidents that did not reach the patient (near miss) may also be reviewed.
- Interdisciplinary in nature with organization-specific and/or specialty-specific criteria for review.
- Similar to a quality of care review and may be conducted under auspices of provincial quality of care legislation.

Debrief

- Also known as a systems review occurring after an incident or training exercise (e.g. post fall, post obstetric emergency simulation, code blue).

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Medical-legal review

- Premise is that patient safety incidents may be the result of individual human errors, which may be negligent.
- Objective is to assess whether a healthcare entity or individual is culpable and to make recommendations about defence of a legal action.
- Legal counsel seeks to determine if negligence led to the patient's outcome.

Insurance adjuster/legal counsel review

- Also known as a medical-legal review.
- Insurance adjusters/legal counsel investigate the details of matters reported to the insurer. They typically interview staff in the presence of the risk manager and possibly the staff member's manager. The adjuster may ask staff initial questions about their involvement while another meeting with legal counsel may be required to understand new issues that have emerged in preparation for examinations for discovery.
- A confidential process.

Practice/competency review

- Takes place when there are concerns about the individual practice/competency of a healthcare provider. This review is typically completed by an individual in a professional practice or clinical role. This review should be completed separately from a systems review and ideally before the systems review occurs.
- Documentation should be objective and include the rationale for the review.

Peer review

- Also known as a practice/competency review to assess if a colleague's work meets accepted standards.
- Used for quality improvement/patient safety.
- May be conducted internally or externally.

Quality assurance review

- Also known as a practice/competency review where the practice of an individual/process is examined in order to measure quality of care. Similar incidents may be reviewed together.

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