Excellent Care For All.

Guidelines for Critical Incident Reporting

Critical Incident Reporting in Hospitals

As of July 1, 2010, hospital boards are now required to ensure that, following the disclosure of a critical incident, the hospital administrator:

- establishes a system for ensuring the incident is analyzed, and
- develops a system-wide plan to avoid or reduce the risk of further similar incidents.

About these guidelines

These guidelines provide a recommended data structure for use in patient incident reporting that will:

- produce consistent data on critical incidents
- support effective data analysis
- enable data-driven decision making and planning to avoid or reduce the risk of future incidents.

Current hospital information systems collect a variety of data that may or may not be coded or categorized in a way that facilitates the analysis of critical incidents. The ministry has produced these guidelines to support improved data collection, analysis and planning, and ultimately to help hospitals provide a safer environment for patients.

What is a critical incident?

A critical incident is defined in Regulation 965 of the Public Hospitals Act as:

Any unintended event that occurs when a patient receives treatment in the hospital,
a) that results in death, or serious disability, injury or harm to the patient, and
b) does not result primarily from the patients' underlying medical condition or from a known risk inherent in providing the treatment

Recommended patient safety data structure

The Ministry of Health and Long-Term Care supports the World Health Organization's (WHO) International Classification for Patient Safety (ICPS) framework (http://www.who.int/patientsafety/implementation/taxonomy/en/). The WHO has created globally appropriate patient safety concepts, with standardized definitions, to facilitate research and the identification of opportunities for health care improvement within and between hospitals

Guidelines for Critical Incident Reporting

Patient Safety Incident Types

To properly collect and manage incident data, hospital systems must be able to identify types of incidents. WHO's ICPS outlines types of incidents that may already be captured by some hospitals' existing reporting systems. It is suggested that these hospitals examine how their systems can be adapted to conform with the WHO ICPS system. It is important to note that, while each incident type group is distinct, an incident can be classified as more than one incident type. Therefore aggregations of incident types may total more than all actual incidents. Incident types include:

- Clinical Administration
- Clinical Process/Procedure
- Documentation
- Healthcare Associated Infection
- Medication/IV fluids
- Blood/Blood Products
- Nutrition
- Oxygen/gas/vapour
- Medical Device/Equipment
- Behaviour
- Patient Accidents
- Infrastructure/Building Fixtures
- Resources/Organizational Management.

Categorizing incident types by level of harm

The WHO ICPS framework helps standardize the definition of critical incidents, including severity and degree of harm:

- **Disability:** is any type of impairment of body structure or function, activity limitation and/or restriction of participation in society, associated with past or present harm.
- **Injury:** is damage to tissues caused by an agent or event.
- **Harm:** is impairment of structure or function of the body and/or any deleterious effect arising there from. Harm includes disease, injury, suffering, disability and death.
- **Degree of harm:** is the severity and duration of harm, and any treatment implications, that result from an incident. The degree of harm may be:
    - **None:** patient outcome is not symptomatic and no treatment is required.
    - **Mild:** patient outcome is symptomatic (mild), loss of function/harm is minimal/intermediate but short term, and no/minimal intervention is required.
    - **Moderate:** patient outcome is symptomatic, requiring intervention, an increased LOS, or causing permanent or long term harm or loss of function.
    - **Severe:** patient outcome is symptomatic, requiring life-saving or major surgical/medical intervention, shortened life expectancy or major permanent or long term harm or loss of function is caused.
    - **Death:** on balance of probabilities, death was caused or brought forward in the short term by the incident.

Mapping existing systems against the ICPS

Existing hospital systems may have identified different harm ratings, using other frameworks. The table on the following page illustrates the mapping of various patient safety classifications to WHO's ICPS framework. A similar mapping exercise for your facility's information can be done to categorize your patient safety incidents into a standard WHO ICPS data structure and, in turn, facilitate the analysis of incident data and delineate a threshold for defining critical incidents. Aggregated critical incident data grouped by the above WHO ICPS incident types can then be reported to the Quality Committee in a consistent manner and be used in analyses to inform hospitals' annual Quality Improvement plans.

Guidelines for Critical Incident Reporting

Mapping Taxonomies to WHO's International Classification for Patient Safety (ICPS) Degrees of Harm				
WHO's ICPS	**CIHI's NSIR***	**Veteran Affairs' (VA) NCPS**	**AHRQ's Common Formats***	**Ontario Hospital Example***
Reportable circumstance A situation in which there was significant potential for harm, but no incident occurred.	**Reportable circumstance** A situation that has potential for harm and does **not** involve a patient.	-	-	-
Near miss An incident which did not reach the patient.	**Near miss** An incident that has potential for harm is intercepted or corrected prior to reaching the patient.	**Close call (near miss)*** An event or situation that could have resulted in an accident, injury or illness, but did not, either by chance or through timely intervention.	**Near miss** A patient safety event that did not reach the patient.	**Near miss** Event which had the potential to cause serious harm but did not due to chance.
No harm incident An incident in which an event reached a patient but no discernable harm resulted.	**None** Patient outcome is not symptomatic or no symptoms are detected and no treatment is required.	-	**No harm** Event reached patient, but no harm was evident.	**Incident** No or slight patient injury, no increased length of stay or level of care
Harmful incident* – Mild harm Patient outcome is symptomatic, symptoms are mild, loss of function or harm is minimal or intermediate but short term, and no or minimal intervention is required.	**Mild** Patient outcome is symptomatic, symptoms are mild, loss of function or harm is minimal or intermediate but short term, and no or minimal intervention is required.	**Minor** Patients with actual or *potential*: no increased length of stay or increased level of care.	**Emotional distress or inconvenience** Mild and transient anxiety or pain or physical discomfort, but without the need for additional tx other than monitoring. **Temporary harm** Bodily or psychological injury, but likely not permanent.	
Harmful incident* – Moderate harm Patient outcome is symptomatic, requiring intervention, an increased LOS, or causing permanent or long term harm or loss of function.	**Moderate** Patient outcome is symptomatic, requiring intervention, an increased LOS, or causing permanent or long term harm or loss of function.	**Moderate** Patients with actual or *potential*: increased LOS; or Increased level of care.	**Additional treatment** Injury limited to additional intervention during admission or encounter and/or increased LOS, but no other injury. **Permanent harm** Lifelong bodily or psychological injury or increased susceptibility to disease.	**Moderate / Adverse event** An event resulting in an increased LOS or increased level of care
Threshold for categorizing critical incidents				
Harmful incident* – Severe harm Patient outcome is symptomatic, requiring life-saving intervention or major surgical/medical intervention, shortening life expectancy or causing major permanent or long term harm or loss of function.	**Severe** Patient outcome is symptomatic, requiring life-saving intervention or major surgical/medical intervention, shortening life expectancy or causing major permanent or long term harm or loss of function.	**Major** Patients with actual or *potential*: permanent lessening of bodily functioning (sensory, motor, physiologic, or intellectual) not related to the natural course of the patient's illness or underlying conditions. **Catastrophic (Sentinel event)** Patients with actual or *potential*: death or major permanent loss of function not related to the natural course of the patient's illness or underlying condition.	**Severe permanent harm** Severe lifelong bodily or psychological injury or disfigurement that interferes significantly with functional ability or quality of life.	**Major Adverse event** Permanent lessening of bodily function not related to the natural course of patients illness of underlying condition.
Harmful incident* – Death On balance of probabilities; death was caused or brought forward in the short term by the incident.	**Death** On balance of probabilities; death was caused or brought forward in the short term by the incident.		**Death** Dead at time of assessment.	**Sentinel event** Death of patient (result of a fall, unauthorized medication departure).
*Harmful incident is an adverse event	***CIHI has implemented concepts in WHO's ICPS and has mapped the NSIR minimum dataset to the conceptual elements of the ICPS framework.	*This system requires reporting of close calls. Mapping to WHO would exclude close calls. http://www.patientsafety.gov/glossary.html	*May be implemented in RL Solutions http://www.pso.ahrq.gov/formats/commonfmt.htm	***System originally based on VA's NCPS taxonomy

Patient Safety Incidents

Critical Incidents