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Question and Answer: Understanding the Critical Incident Process

In 2006, Manitoba introduced mandatory no-blame critical incident reporting across the health system to support a culture of learning and openness. Critical incidents are not reported to lay blame on any one individual. The purpose of reporting is to look at what can be done differently and what improvements can be made to the way health care providers work. This process does not replace other disciplinary investigations such as reviews by employers, complaints to professional regulatory bodies or civil law suits. Instead, investigating critical incidents complements these processes.

To encourage reporting and full, open participation in the investigation by health care providers, some parts of the investigation process, including opinions, speculations and advice, are confidential and privileged under law. This is intended to support providers and encourage them to speak frankly and openly about what occurred. This approach is used in several jurisdictions around the world.

For more information please visit: http://www.gov.mb.ca/health/patientsafety/ci/

Q: What is Occurrence Reporting?

A: Occurrence, Injury/Near Miss and the Critical Incident processes are designed to allow DSM to investigate and analyze adverse events so that learning and improvements or changes can be incorporated in a "non-blaming" environment.

Occurrences are classified as follows:

- A **Critical Occurrence (CO)** is an Occurrence that does not involve a client/resident/patient. It involves substantial risk or harm to employees, DSM staff, volunteers, students and workers provided through contracts and to property, reputation or security.

- A **Near Miss (NM)** is an event which, if undetected and/or not corrected through timely intervention, could have resulted in an undesired patient outcome, including disability, death, admission to hospital or prolonged hospital stay, and which was not the result of the patient's underlying health condition.
- A **Critical Incident (CI)** is an unintended event that causes serious harm to a patient, resident or client in the health care system and which does not result from the individual's underlying health condition or from a risk inherent in providing the health services.
- **Provisional Critical Incident** is an event that may meet the above criteria but has not yet been designated a CI. Any information collected prior to designating an event as a CI is not legally privileged.

Q: Why are Critical Incidents even reported?

A: These are reported within a blame-free environment to learn from the incident and to recommend quality and risk management improvements to diminish the chance of a recurrence and to enable patients, families and health care providers to participate in patient safety improvement.

Again, this process does not replace other disciplinary investigations such as reviews by employers, complaints to professional regulatory bodies or civil law suits. Instead, investigating critical incidents complements these processes.

Q: Who is responsible for reporting a CI?

A: Any employee or DSM Medical Staff, or any individual with the information, including patients and family members.

Q: How are CIs Investigated?

A: For a CI, a Critical Incident Review Committee (CIRC) is formed as soon as possible after an event. A CIRC will reconstruct the sequence of events by interviewing the involved staff; interviewing other health care professionals and organizations as required; and gathering records and documents. If applicable, a CIRC may refer the issue to the applicable DSM Standards Committee.

Q: What role does the Quality Assurance and Standards Committee play in the investigation?

A: The purpose of a Standards Committee of the College of Physicians and Surgeons of Manitoba (CPSM) and its sub-committees is to "promote high practice standards amongst Physicians".

If an issue is identified with a physician's practice, the Committee will make a recommendation; for example, remedial activities. If the Committee is subsequently satisfied that the remedial action has been successful, no further action is likely. If the remedial action is unsuccessful, or if the physician refuses to follow the recommended action, the Committee may refer the matter.

The deliberations of Standards Committees are confidential and protected by *The Evidence Act.* The investigations are not reported to DSM except as noted above.

Q: What is Disclosure?

A: Disclosure is the process (verbal and written) of informing the client/family or other individuals authorized by regulations to receive information about CIs. Disclosure generally takes place after the patient's care needs have been met and often over a period of time. Disclosure is made using the Canadian Patient Safety Institute - Canadian Disclosure Guidelines. In DSM, the Chief Medical Officer has been designated to provide Disclosure, when required.

Q: How will CIRC information be used?

A: The Regional Health Authorities Amendment Act and the Manitoba Evidence Act outline restrictions on access to, and use in legal proceedings of, information and reports generated by a CIRC as well as notifications, reports and information provided to DSM and/or the Minister (Manitoba Health). This is to enable the incident to be investigated without fear of reprisal and also ensure that the purpose of the investigation is to determine ways in which a similar event can be prevented from occurring in the future.

No record or information, including an opinion or advice, prepared solely for the use of a CIRC may be produced in any legal proceeding.

Q: What happens to the results of the CI investigation?

A: DSM reviews all recommendations and initiates steps and recommendations to reduce the risk of recurrence. The CIRC lead will send a copy of the final report on CIs to the Minister of Health (Manitoba Health).

Q: What are Learning Summaries?

A: A Learning Summary is a communication tool that provides a description of the Occurrence and what corrective or preventive actions were recommended. The intent is to be educational. They are distributed internally to facilitate broader learning from critical incidents and prevent recurrence. All identifying information is removed from the description of the Occurrence.