## Introduction

Critical incident reporting is an important part of monitoring safety and learning from events. There are multiple tools available for reviewing adverse events and analysing causation before taking action.

## Purpose

To provide resources that support active reflection on events, by complaint and adverse event analysis, mortality and morbidity meetings, case note review and prospective hazard analysis.

To provide templates and resources to allow a structured approach to safety.

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<tr>
<th>Objective 1</th>
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<th>Evidence and Resources</th>
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| To understand incident reporting and analysis. | It is important to understand the barriers and incentives to incident reporting as well as appreciate the strategies that can be used to increase the number of reports submitted. | **Barriers and overcoming them:**


### Objective 1

**Action**  
[http://qualitysafety.bmj.com/content/18/1/11.abstract](http://qualitysafety.bmj.com/content/18/1/11.abstract)


[http://qualitysafety.bmj.com/content/early/2012/03/14/bmjqs-2011-000443.full](http://qualitysafety.bmj.com/content/early/2012/03/14/bmjqs-2011-000443.full)

A scoping study which identifies how the effective use of design could help to reduce medical accidents.  
Engineering Design Centre, Design for Patient Safety  
[http://www.edc.eng.cam.ac.uk](http://www.edc.eng.cam.ac.uk)

### Objective 2

**Action**  
Incident analysis is more than just collecting information – appropriate reflection, analysis of events and team discussion of what the department was like at the time is crucial to understand why and what happened and therefore how the risk of recurrence can be reduced.

**Evidence and Resources**  
NHS Patient Safety Resources, Root cause analysis information and evaluation  
[http://www.nrls.npsa.nhs.uk/resources/?entryid45=75602&q=0%2acroot+cause+analysis%2ac](http://www.nrls.npsa.nhs.uk/resources/?entryid45=75602&q=0%2acroot+cause+analysis%2ac)

[http://www.biomedcentral.com/1472-6963/13/50](http://www.biomedcentral.com/1472-6963/13/50)

[http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2464895/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2464895/)

[http://qualitysafety.bmj.com/content/18/4/288.abstract](http://qualitysafety.bmj.com/content/18/4/288.abstract)
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<th>Objective 2</th>
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| continued  |        | Imperial College London, The London Protocol [link]  

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<th>Objective 3</th>
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<td>To appreciate the utilisation of routine audit or M&amp;M meetings to identify risk and reduce hazards.</td>
<td>These can be a useful way of monitoring the care of critically ill patients or sentinel conditions.</td>
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<tr>
<td>Objective 3</td>
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http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2723204/ | Morbidity and mortality conferences: Their educational role and why we should be there. Epstein NE. Surg Neurol Int. 2012;3(Suppl 5):S377-88  
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3520073/ | |

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<th>Objective 4</th>
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<th>Evidence and Resources</th>
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| To understand how case note review can be used to identify errors or harm. | Routine small scale review of notes can demonstrate recurrent, and often hidden, errors or risks to safety. | Evidence that errors are detectable by routine review  
http://qualitysafety.bmj.com/content/early/2012/07/06/bmjqs-2012-001159.full | To what extent are adverse events found in patient records reported by patients and healthcare professionals via complaints, claims and incident reports? I Christiaans-Dingelhoff et al. BMC Health Serv Res. 2011 Feb 28;11:49  
http://www.biomedcentral.com/1472-6963/11/49 | |

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<th>Objective 5</th>
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| To understand the purpose of prospective hazard analysis in reducing risk. | Analysing and depicting complex systems highlighting weaknesses and vulnerable areas. A variety of techniques are available to predict failure before it happens. | What happens when one part of a pathway fails  
The Institute for Healthcare improvement has a tool for failure modes and effects. A tour of this tool can be found below:  
Institute for Healthcare improvement, Failure Modes and Effects Analysis (FMEA) Tool  
http://www.ihi.org/knowledge/Pages/Tools/FailureModesandEffectsAnalysisTool.aspx  
http://app.ihi.org/Workspace/tools/fmea/  
Using Health Care Failure Mode and Effect Analysis - The VA National Center for Patient Safety’s Prospective Risk Analysis System, J Derosier et al.  
http://www.generalpurposehosting.com/updates/HFMEA_JQI.pdf  
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| continued  |        | **Use of FMEA in a pathway analysis**  
  Using a multi-method, user centred, prospective hazard analysis to assess care quality and patient safety in a care pathway. J Dean et al  
  [http://www.biomedcentral.com/1472-6963/7/89](http://www.biomedcentral.com/1472-6963/7/89) |
|            |        | **Example of best practice**  
  This PhD is an example of best practice into a specific clinical question  
  The evaluation of methods for the prospective patient safety hazard analysis of ward-based oxygen therapy. M Durand  
  [http://dspace.lib.cranfield.ac.uk/handle/1826/4480](http://dspace.lib.cranfield.ac.uk/handle/1826/4480) |

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<th>Objective 6</th>
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<th>Evidence and Resource</th>
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| To utilise data from complaints to analyse risk to patient safety. | Complaints may give a different view of the department and the work therein – identifying situations where normal practice is not followed. | **Clinical complaints: a means of improving quality of care.** P Bark et al Qual Health Care. 1994 Sep;3(3):123-32.  
  Using Patient Complaints to Promote Patient Safety, James W. Pichert, PhD, Gerald Hickson, MD, and Ilene Moore, Advances in Patient Safety Vol 2.  
  This website provides guidance on how to improve complaints handling in the NHS. Parliamentary and Health Service Ombudsman, Getting it right: our work in the new NHS  
  Learning from complaints about general practitioners - Clinical governance means handling complaints better - for both parties, Richard Baker, BMJ. 1999 June 12; 318(7198): 1567–1568.  
  [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1115948/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1115948/)  
  The role of the patient in clinical safety. R Lawton and G Armitage, The Health Foundation 2012  