

Assessment of the Distribution of Critical Incident Learning Summaries

Recipient of the **2008 Dr. John Wade Research Award**
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Executive Summary

The increased focus on the investigation of Critical Incidents (CIs), coupled with the changes in provincial legislation limiting the distribution of the final Critical Incident Review Committee (CIRC) reports led the Patient Safety (PS) team to seek opportunities to share the otherwise protected information. Accordingly, the Critical Incident Learning Summaries (CILS) were conceptualized and broad distribution was initiated in April of 2008. The stories or cases were created by a small editorial team of Patient Safety staff members. Although abstracted from actual critical incidents, the cases were de-identified according to patient and health provider names, age, gender, and site/setting before being circulated. The CILS began with the category of the case, e.g. medication, diagnosis, etc. and relevant aspects of the abstracted case being shared in a "story" format. Although the narrative, findings and recommendations were summarized, the salient points were retained. The editorial team took particular care not to change the intent or the content of the findings and recommendations.

A survey assessed the perceptions and usefulness of the CILS by healthcare providers; as well as providing information about the extent of CILS distribution. The survey results were used to inform the development of a focus group question guide. Two (2) focus group sessions were audio taped, transcribed, and analyzed on qualitative content. In total, there were six (6) focus group participants. In order to maintain anonymity, the participants' first names and genders have been de-identified. Fictional names, Andrea, Anne, Bob, Brent, Cora, and David are used to quote individual participants in the following document.

Seven major themes emerged from the two focus groups. The first theme, *"Becoming Aware"* focuses on some of the ways in which participants first heard about the CILS. As the CILS were initially distributed to site and regional senior management as well as the majority of site and program directors, it was interesting to note the formal and informal channels that were used for sharing the CILS. The second theme *"Reading and Selecting"* refers to the process that participants followed to prioritize the CILS that were chosen for reading and sharing the stories. *"Disseminating and Using"* was the third theme that emerged from the focus groups. Here participants discuss some of the innovative ways in which the CILS were used and shared. The theme *"Stories"* emerged from participants' discussions of the connection between the Critical Incident findings/recommendations and the creation of the CILS. Areas such as the level of detail included and the context of the case are included under this theme. The fifth category *"From Who to What"* describes the level of anonymity and the recognizability of the CILS cases. A number of the participants' expectations are discussed here. The sixth theme *"Learning from the CILS"* primarily outlines ways in which the CILS are being used to promote learning and to change the behaviors of present and future healthcare providers. The final theme *"Distributed Learning"* again touches on how the CILS are used to promote knowledge dissemination.

Study results identified important ways in which the distribution of the CILS can be improved. Although the number of focus group participants was small, these improvements have the potential to directly benefit many other providers. As such, the results of this study will be shared widely with all current recipients. In addition, the comments will be used to improve the CILS as well as produce other types of relevant patient safety information. In addition to adding other individuals and groups, the usual dissemination methods and formal networks currently employed by the PS team will remain.

The Aim of the Project

The reduction of preventable injuries to patients is a critical element of patient safety efforts.

One approach to achieve harm reduction is to review critical incidents to understand the various factors that have contributed to a particular event. The WRHA undertakes such reviews and the findings lead to recommendations to improve the way in which services are provided in the location in which the incident occurred.

Following a Critical Incident Review Committee (CIRC) review and analysis of a critical incident (CI), a de-identified, summarized version of the final report (CILS; see example in Appendix A) including a description of the event, findings, and recommendations is created for selected cases. This activity has been ongoing since the Spring 2007. CILS are produced for CIs where the learning potential goes beyond the scope of the reviewed event and only those recommendations with systemic learning potential are included in the CILS. Because the review of critical incidents in Manitoba is legally protected under the Evidence Act, the CILS necessarily are significantly de-identified (site, gender, terms specific to certain settings, etc.). Patient Safety strives to provide enough information to stimulate learning in other units, facilities and regions across the country, while respecting the duty of confidentiality. With the goal of facilitating broader learning by providers and facilities throughout the healthcare system, the Winnipeg Regional Health Authority (WRHA) recently (April 2008) began to systematically distribute these summaries (via email) to all settings within the WRHA, provincially and nationally.

The purpose of this research project was to assess the perceptions of targeted recipients of the CILS concerning the usefulness of the CILS in their practice setting as well as to determine the extent of the distribution.

Background Information

WRHA is similar to most other large healthcare systems in North America with respect to the relatively low level of reporting of critical incidents. It is generally acknowledged that one reason for this is the lack of feedback provided to staff following a critical incident review.

Case studies have been used as a teaching tool in health disciplines' faculties for many years. Other organizations have shared cases more broadly (for instance the Institute for Safe Medication Practice in Canada and the US as well as the Agency for Healthcare Research and Quality in the US) in an effort to promote understanding of common patient safety challenges.

However, there are no published reports of hospitals or healthcare systems systematically distributing critical incident case summaries as a way of disseminating learning. An additional benefit of such distributions may be the concrete demonstration to staff that reporting leads to learning. In this regard, we believe the WRHA efforts are unique.

Prior to the beginning of the research project, the WRHA had distributed three groups of CILS (in April, July, and September). Each group distributed included at least ten CILS drawn from various healthcare settings that reflected different types of clinical patient safety challenges. The distribution list is comprised of individuals and organizations with a range of interests (direct care providers, administration and managers, regulators, health disciplines faculties, various governmental and para-governmental agencies, as well as not-for-profit organizations with a mission to promote safe quality healthcare).

The Research Project

This project received the 2008 Dr. John Wade Research Award from the Manitoba Institute of Patient Safety. This research assessed the perceptions and attitudes of the recipients of the first three groups of CILS. The focus was specifically on the perceptions and attitudes of recipients (individuals and organizations) regarding the usefulness of the CILS as part of a patient safety strategy. Approval for this project was received from the University of Manitoba Research Ethics Board and the WRHA Research Review Committee.

Objectives: Research Questions

1. What are the perceptions and attitudes of the targeted CILS recipients regarding the usefulness of distributed CILS as part of their patient safety strategy?
2. What specific challenges are being encountered during the distribution of CILS?

Research Methods

A mixed method approach (see process map in Appendix B) that included questionnaires and subsequent key informant focus groups was used to maximize the richness and usefulness of data.

A survey instrument (questionnaire) was developed using an online survey tool. Questions were assessed for face validity and the online survey (URL link) was forwarded to a group of individuals (acute care and personal care home sectors) involved in regional patient safety work for pilot testing. Responses and feedback from this group were used to create the final version of the survey.

The URL link for the final version of the survey with a printable PDF version (see Appendix C) attached was emailed to each person who was named on the CILS distribution list. Some recipients (n=34), chose to complete and return a hard copy of the survey rather than use the on-line version. The response data from these hard copies was manually entered into the electronic survey tool by one of the co-investigators.

Key informants could self-identify as willing to participate in a focus group or complete the questionnaire anonymously. The responses from the online survey were used to develop questions and identify participants for the focus groups. Positive responses to the survey participation question on the survey were good (n=21), however, as a quality improvement project the co-investigators were unaware that this project required Ethics Board approval. Once aware, application for this approval was made and granted, but this delayed the arrangement of the focus groups and the contact of participants for approximately five months. Several of those willing to participate in a focus group were unable to do so given the short turnaround time from contact until the session date. As well, the project time frame did not allow for recruitment of additional focus group participants by other means.

The number of focus group sessions planned was based on the number of potential focus group participants. Potential focus group participants were contacted to determine their availability which, as mentioned above, was somewhat limited by the quick turnaround time. Although the number of key informants able to attend a focus group session was small, this may have allowed for more in-depth discussion. Based on availability, the facilitator (contracted by WRHA Patient Safety) selected the key informants for each group. There were four (4) key informants

in the first focus group and three (3) in the second; however, one individual unexpectedly declined for the second focus group session leaving two participants. At the beginning of each focus group participants and the facilitator reviewed and signed a consent form. (See sample Appendix D)

Based on issues identified in the survey responses, focus groups were conducted with the key informants to more fully assess perceptions and attitudes regarding the CILS. Focus groups were facilitated by a qualitative health researcher with questions based on issues identified in the survey responses and designed to encourage discussions centered on substantive issues (such as the way in which information is presented in a CILS) as well as process issues (how the distribution worked for a specific recipient).

Survey results were analyzed using SAS 9.1.3 software. Focus group data were analyzed using content analysis derived from a grounded theory approach with NVIVO8 software.

Focus Group Methods

Both focus groups were audio taped and transcribed. Each focus group included two observers who documented general environmental quality and participants' body language and emotional responses. These notations were added to the transcribed focus group documents. Additionally there was a short debrief session between the facilitator and the two observers after each focus group. These sessions were also taped, transcribed, and coded. Coding and analysis was performed with NVIVO8 software. The coded segments were used to provide context to the focus group text.

The initial coding produced 11 tree nodes with 23 branches. The final coding added two tree nodes and two additional branches. The final tree nodes are shown in Table 1. Themes emerged from the process of coding nodes, drawing relationships between nodes and creating three memos, which were: *First became aware of the CILS*, *Learning from the CILS* and *Misconceptions*. These memos became the body of text which produced the themes which are the results of the focus groups.

Table 1: Tree nodes showing the coding of focus group transcripts.			
Tree Node	Branch Node	Sources	References
Accessing CILS		6	25
	Associations		2
	Inter & intranet		4
	Posting		3
	Public		7
Became aware of CILS		2	2
	By email		2
	Patient Safety Team		4
	Staff		3
CI process		8	22
	Follow-up		2
	Recommendations		5

Table 1: Tree nodes showing the coding of focus group transcripts.			
Tree Node	Branch Node	Sources	References
	Reporting		3
	Statistics		4
CILS development		6	26
	De-identification		5
	Details		6
	Stories		5
Culture		7	28
	Change thinking		5
Error		6	15
	Blame		6
	Systems & patterns		6
How using the CILS		7	28
	All or some		3
	What is pertinent		4
Learning from a CILS		6	25
	Practice & context		8
	Programs & sites		5
	Recognitions & reassurance		5
	Responsibility & accountability		4
	Students-staff education		6
Misconceptions		7	57
Opportunities		7	31
Perspectives		6	19
	Response to CILS		4
Purpose of the CILS		2	2
Time Frames		4	23

Results

It was anticipated that research findings would identify important ways in which the distribution of CILS can be improved. These improvements will have the potential to directly benefit many other providers, including those who have limited resources for education regarding patient safety.

These results will guide future development of the CILS distribution process by the WRHA Patient Safety Team. As well, this pilot project is the first step in a much broader assessment of the promotion of the system-wide dissemination of learning regarding patient safety.

CILS Survey Results

In total, 154 surveys were completed: 21 respondents had never seen a CILS, 13 respondents were non-staff (not included in the analysis), 26 respondents were direct care providers and 94 respondents were indirect care providers (See Figure 1 below). Relatively few direct care providers responded to the survey (22% direct care; 78% indirect care). Not surprising 61% of respondents were from acute care settings as the distribution list is heavily weighted to that setting.

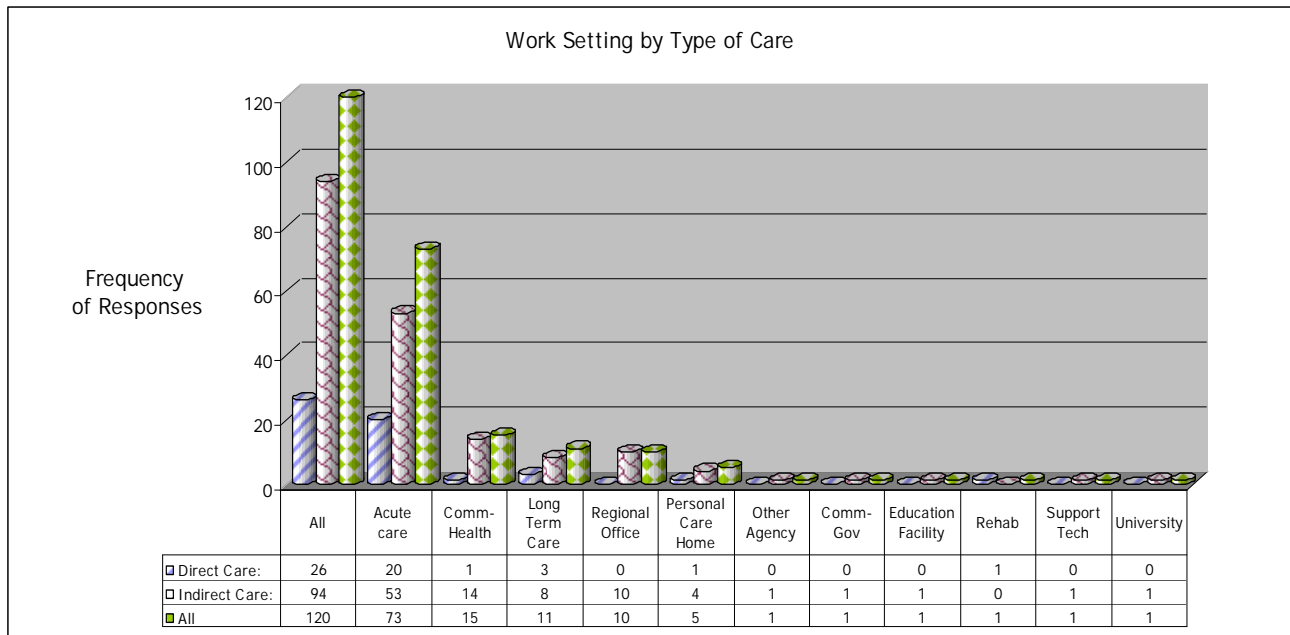


Figure 1: Type of work settings of CILS Survey respondents by either direct care or indirect care.

Physicians (54%) were the largest group of direct care providers responding. Since the distribution of the survey mirrored the distribution of the CILS we can infer that few direct care providers, especially those outside of acute care, and in particular non-physicians, are seeing the CILS. The frequencies and percentages of respondents according to their declared role within the different healthcare settings are shown in Tables 2 and 3. Table 2 shows this for direct care staff while Table 3 shows the same for indirect care staff.

Most survey respondents (91-96%) said the CILS are informative, easy to understand, and purposeful. However one quarter of respondents were unsure or disagreed that the CILS help them to understand how WRHA intends to learn from critical incidents. Interestingly 40% of respondents were unsure or disagreed that the CILS would be an incentive for a direct care provider to report a critical incident. Of the indirect care providers 35% responded this way, while a much larger percentage (58%) of direct care providers (54% of those were physicians) responded this way. This was a revealing result, which was pursued in the focus groups. Despite disagreement in this one aspect of the benefits of the CILS, 91% of respondents said they would recommend others to read the CILS and 73% agreed that the CILS would help in reducing preventable harm. Only 21% of respondents were unsure or disagreed that the information in the CILS was applicable to their work in healthcare.

Most survey respondents said they read all of the multiple summaries from all three groups of CILS. Most survey respondents said they received the CILS through email (42%), from a supervisor or colleague (32%) or at a meeting (16%). One third of survey respondents said they had not seen the CILS posted anywhere; while 16% saw these posted on a unit, 13% reported seeing the CILS in communication books. Only 3% reported seeing the CILS posted in areas accessible to the public. Figure 2 shows the different locations where the CILS were seen posted or made available.

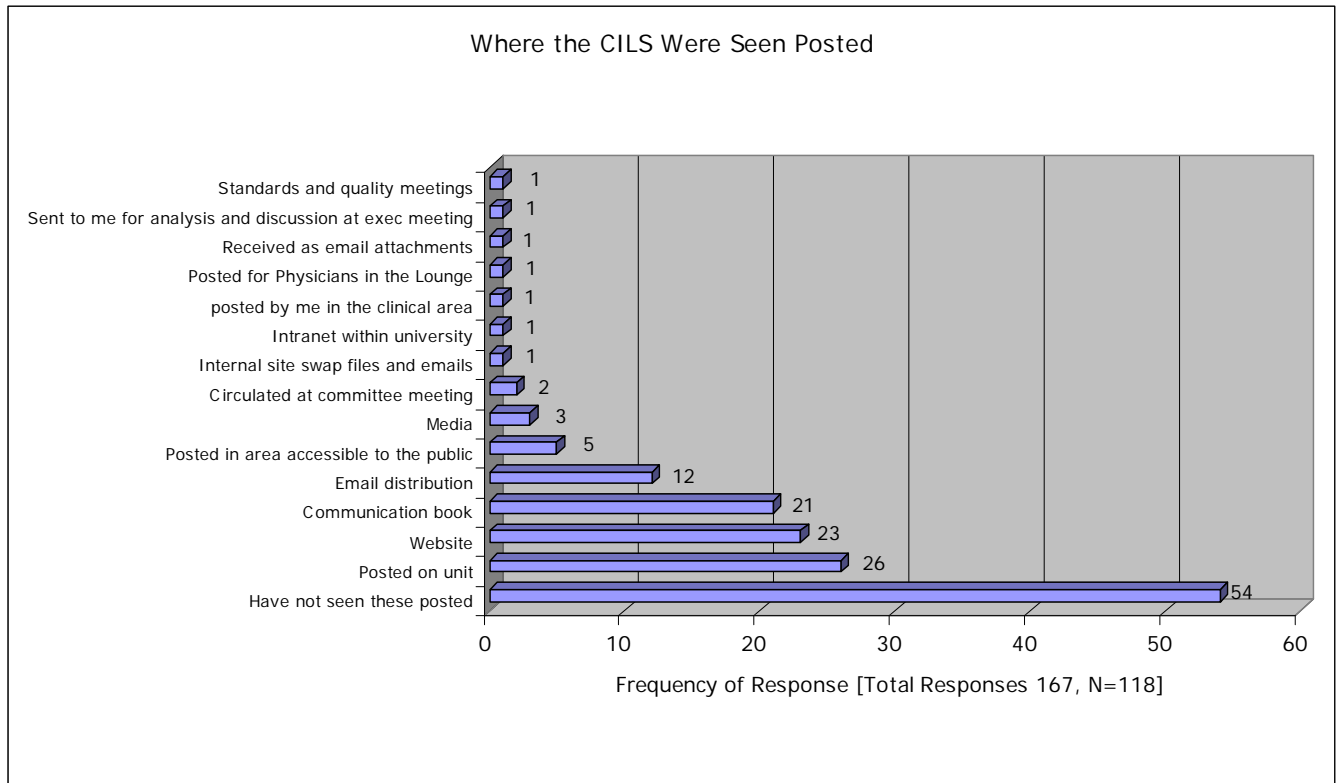


Figure 2: Frequencies for different locations where the CILS were seen posted or available.

In the additional comments provided in the survey some respondents expressed that they felt responsible to 'act' on the information in the CILS and therefore thought details and guidelines for use were needed. These respondents seemed to be unaware that CILS are meant as a source of information to promote learning from discussion. A number of respondents also seemed unaware that when a Critical Incident Review Committee (CIRC) investigates a CI, they make recommendations and ensure the appropriate persons, sites and programs are consulted and informed throughout this process.

Surprisingly some respondents felt that the CILS could be harmful to confidence in the healthcare system and in particular would be damaging to public perception. Referring use of the CILS within the CI process, one respondent said *'The comment I hear routinely from families and patients is "[I]s this it?" It does not move them along the journey of healing in any way.'* One other comment received in the survey addressed the continuing punitive culture of our healthcare system and felt that the providers are too over-worked to make use of the CILS.

Table 2: Work settings of CILS Survey direct care respondents by type of role in healthcare.			
Work Setting	Role	Frequency	Percent
Acute care	Allied Healthcare:	3	11.54
	Nurse	4	15.38
	Physician	12	46.15
Acute care	Total	19	73.08
Community Healthcare	Dentist	1	3.85
Long Term Care	Clinical Nurse Specialist	1	3.85
	Nurse	1	3.85
	Physician	1	3.85
Long Term Care	Total	3	11.54
Personal Care Home	Nurse	1	3.85
Diagnostic Services	Allied Healthcare:	1	3.85
Rehabilitation	Physician	1	3.85
Total	Allied Healthcare:	4	15.38
	Clinical Nurse Specialist	1	3.85
	Dentist	1	3.85
	Nurse	6	23.08
	Physician	14	53.85
Grand	Total	26	100.00

In the additional comments, direct care providers were far more critical of the CILS than the indirect care providers. One of the areas both were concerned about was the translation of the CILS information into concrete change; that is, how to make this information useful. In general many felt there was not enough information, for example in the details on steps to be taken or on the follow-up of the recommendations. One respondent commented that we must *"...demonstrate that the recommendations are acted on. That change not only is possible but that it occurs."* There seemed to be a variety of expectations on how the CILS could or should be made useful. Another comment suggested that there should be a follow-up report (made public and as widely distributed as the CILS) which looks at each incident indicating what has actually been done to address the recommendations. Yet another respondent said that:

Of the three CILS to date, we've spent more time trying to understand the context of the event and how it might apply to our areas of responsibility in the WRHA than making any clear plan to translate the knowledge. It is not clear what if anything is expected to be done, or who if anyone is expected to do something with the information. It's not that the information isn't appreciated, but frankly, we're getting more knowledge translation mileage out of CI published in letters to the editor, Health Canada advisories, mailings from organizations like ISMP, or shared by colleagues in other regions via emails or at roundtable discussions at professional meetings than we have from CILS in our own region.

Thus the survey was very useful to inform the types of issues and questions the focus groups should address. Please see Appendix E for the finalized focus group guide.

Table 3: Work settings of CILS Survey indirect care respondents by type of role in healthcare.			
Work Setting	Role	Frequency	Percent
Acute care	Administrator	8	8.51
	Clerical	1	1.06
	Clinical Engineer	1	1.06
	Consultant	4	4.26
	Director	10	10.64
	Educator	9	9.57
	Infection Prevention & Control	1	1.06
	Manager	17	18.09
	Research	1	1.06
Acute care	Total	52	55.32
Other Agency	Clerical	1	1.06
Community Healthcare	Administrator	3	3.19
	Director	8	8.51
	Manager	1	1.06
	Educator	1	1.06
	Patient Advocate	1	1.06
Community Healthcare	Total	14	14.89
Community and Government	Director	1	1.06
Educational Facility/University	Educator	2	2.13
Regional Health Authority	Administrator	3	3.19
	Director	5	5.31
	Manager	1	1.06
Regional Health Authority	Total	9	9.57
Long Term Care	Administrator	2	2.13
	Director	2	2.13
	Educator	1	1.06
	Manager	3	3.19
Long Term Care	Total	8	8.51
Personal Care Home	Administrator	2	2.13
	Director	1	1.06
	Manager	1	1.06
Personal Care Home	Total	4	4.26

Table 3: Work settings of CILS Survey indirect care respondents by type of role in healthcare.			
Work Setting	Role	Frequency	Percent
Supporting technology	Director	1	1.06
Ambulatory/LTC/Acute Care	Patient Safety	1	1.06
Patient Safety	Manager	1	1.06
Total	Administrator	18	19.15
	Clerical	2	2.13
	Clinical Engineer	1	1.06
	Consultant	4	4.26
	Director	28	29.79
	Educator	13	13.83
	Infection Prevention & Control	1	1.06
	Manager	24	25.53
	Research	1	1.06
	Patient Advocate	1	1.06
	Patient Safety	1	1.06
Grand	Total	94	100.00

Focus Group Results and Discussion

Becoming Aware

Depending on the participant's role in the healthcare system they became aware of the CILS either through many formal sources or through informal conversation. In fact Bob could not recall how the CILS first came to his attention; however he noted that he was not the first person in his RHA to receive them. When he became aware of the availability of the CILS he contacted someone [title of this person was not provided] to be put on the mailing list. Three other participants clearly recalled that email was their initial introduction to the CILS. Anne surmised that she received these as a result of no longer working in direct care; thus an indirect care role included being on a few mailing lists.

Formal routes to receiving the CILS that are mentioned include standards committees and WRHA programs. Managers in particular are cited as the most likely recipients of the CILS. Being deeply embedded in the formal structure of WRHA David has a heightened profile and awareness of CIs. For him becoming aware of the CILS was more than a result of being on a few mailing lists. His experience with CIs and responsibilities in this regard promoted an active interest for him in receiving this sort of information. He said:

And that's one of the reasons why I come back to trying to get a sense of the aggregate number of incidents...the kind of recommendations that are being made...the kind of recommendations that come up repeatedly that don't make it to the CILS level. Now [the] Patient Safety group [WRHA Team] maybe having [has] some sort of overview

process that is saying "*Here we have all of these hundreds of CI's and we are looking for patterns*". And maybe the CILS are outcome of that. But I'm kind of presuming a lot....So for us it's kind of, it should be old news and we are kind of looking for something that the system has missed. Something that happened way over there that is somehow pertinent to our practice which is I think [is] a missed opportunity here. [[<Internals\Focus group transcripts\Group 1 Text_21apr09>](#)]

Brent described an informal route, as he "...became aware of that these were happening through a conversation with [a member of the Patient Safety Team]. We had met about something completely different and these came up." [[<Internals\Focus group transcripts\Group 2 Text_24apr09>](#)]

However Bob was quite clear that a formal route is a preferable, but not always successful way to become aware of the CILS.

Well I think Patient Safety [WRHA Team] is probably essential in the communication link. Because I think initially they [the CILS] did go to senior management [in his RHA], and should have been funneled down right to me so I could have disbursed this, but wasn't, and like I said I had to request that. So I don't think senior management should be excluded. [[<Internals\Focus group transcripts\Group 2 Text_24apr09>](#)]

Referring again to WRHA Patient Safety, Bob explained that past contact with the PS Team has provided for continuing contact and learning; of which the CILS is one aspect.

Reading and Selecting

Up to the time the focus groups were conducted there had been three groups of CILS with multiple summaries (approximately 10 in each group) sent out by WRHA Patient Safety. Most participants saw all three groups and at least three of the six read all of those received.

Of more interest, is that specific CILS were chosen for further use or dissemination. The pertinence of a certain CILS to a field of practice or program area was for most participants the deciding factor on whether or not there was value in the promotion of the CILS. Referring to the staff in her unit Andrea said "They talk about them and I see them reading them....if they are pertinent to our area....I'll talk about them at a staff meeting. I won't talk about them all. I'll talk about specific ones that have relevance to us." [[<Internals\Focus group transcripts\Group 1 Text_21apr09>](#)]

Thus pertinence of the CILS subject is the key to most of participants' use of CILS beyond casual reading. As a staff involved in CI investigations Cora uses specific CILS that prove to have insight into the work of her and her colleagues in acute care. For Bob, although the ability to target specific CILS is an important requirement in the dissemination of these, he found that it was impossible to separate these within the single PDF. David said that as a committee they throw away the majority [those not relevant to their program] and then try to figure out if there is any new knowledge in the remaining ones, and whether or not they should be trying to make similar changes. This idea of using the CILS to implement change is a topic that came up repeatedly in the groups.

Disseminating and Using

Participants focused not so much on whether their colleagues were reading the CILS but rather how the CILS were being used. Brent noted that the CILS form the basis of case conferences within his faculty. Cora uses the CILS to follow-up with families and care providers when these are about her specific cases. She is usually involved in the development of the CILS of her cases so knows precisely which ones are relevant to her clients and staff. Interestingly almost all participants felt they and their staff knew when a CILS was about their facility, unit, or staff.

Other ways cited of disseminating and using the CILS include: discussions at standards and quality meetings; sharing with CRNs and other managers for further dissemination to their staff; presentation at facility orientation; and inclusion in a culture of safety presentation. One particularly novel use of the CILS was described by Bob who said the relevant CILS recommendations were put into a table and rated for RHA risk. Anne summed up one way the CILS are accessed and used in an acute care setting:

I just know I get them in an email. I print them off and read them, and then the ones that jump out at me, I try and do huddles. And then we keep minutes about our huddles and that's how we disseminate. Or I disseminate the information that way, so it's not the actual CILS in the book but it's taking the CILS...even watering it down a little bit more, and then making minutes from that, and putting those minutes in our huddle book...Everyone has access to those, from the unit clerk to the physicians if they wanted to look in it....if it's applicable to them the unit clerks are invited to the huddle, and they actually discuss it with us at that moment, so yes. The cleaners come, if it's applicable to cleaners.... [[<Internals\Focus group transcripts\Group 2 Text_24apr09>](#)]

Stories

One of the participants was confused as to the difference between receiving a recommendation to be implemented (either as a site or regional role) and the CILS. This led to some discussion in group one as to whether or not there was enough information provided with recommendations passed on to be implemented. Eventually it was noted that at some sites the entire CIRC report is provided to implementers while at other sites only the bare-bones recommendation is provided. Although this discussion did not relate directly to the CILS it effectively led to the topic of needing to tell a story; that is, provide a salient context if information is to be understood. Andrea related this confusion with this comment, 'Sometimes we get recommendations and you're kind of thinking "*Where did that come from?...and why should I do that?*" Like if you had the story that went with that you might say "*Yeah, you're right*" ' [[<Internals\Focus group transcripts\Group 1 Text_21apr09>](#)] Cora related how the recommendations can differ from CILS to CILS and the difference this can make to the reader:

It's a concrete one. So you can see how the puzzle fit together and why it unfolded as it did so you can maybe look to make the change. But, they're not real concrete and you don't see. It's too wishy-washy then you don't know how to run with it and make the changes. [You] Decide okay it must not be us we didn't get the full report so.... [[<Internals\Focus group transcripts\Group 1 Text_21apr09>](#)]

To this point Cora added that a recommendation as described in a CILS needs to be very tightly connected to the story of what happened, where the breakdown occurred, and clear as to why one would want to make this change. Or as David put it, "...you really do have to tell a story. Spin the case in such a way that it leads the reader to the conclusion without, you know,

disrespecting the facts." [[<Internals\Focus group transcripts\Group 1 Text 21apr09>](#)], and as Andrea put her slant on what was needed:

I think stories are powerful. I think the story format maybe it could be....it's hard because it has to be de-identified so you've got to [know] some of the details which might be the real grabbers [that] really can't be in it because... [[<Internals\Focus group transcripts\Group 1 Text 21apr09>](#)]

Although the current CILS are considered succinct and the consensus is that being able to print one CILS on a double-sided single page is preferable the dialogue around the stories as told and needed was always for more detail and context; or what Andrea so colorfully described as 'the real grabbers'. And the question remains as to whether or not 'the real grabbers' are those details that must be de-identified or whether there is a way to relate the 'story' of the CI such that it captivates and educates. Anne described one CILS story that had the CRNs exclaiming, 'Look at this one...this is a really good one,' [and] they're like "I want more! What else? What else?" they say, "What else?" Like they want more to the story.' [[<Internals\Focus group transcripts\Group 2 Text 24apr09>](#)] Going beyond the need to and value of telling the story of a CI, David suggested there is more than one avenue to this end:

Well this issue of writing these things up and spinning them I think is...it's important and it's unimportant. It's the spinning, [that] should be to tell the story and emphasize the underlying point as opposed to trying to be as accurate. I mean obviously they have to be accurate, factually accurate. But there are different ways of telling the story I guess. [[<Internals\Focus group transcripts\Group 1 Text 21apr09>](#)]

And although the key to this option he suggests lies in the amount of fictitious, possibly 'window dressing' information that is used to 'spin' the story the group did not pursue further the question of whether such a 'story' would in fact function differently than is the intention for the CILS. But regardless of what was the original intention of the CILS, the participants were clear as to what is needed and what impact it might have. As Andrea summarized:

So I guess what I am trying to say is, to try to write this to make maximum impact you have to tell a story and get your audience interested in it. You have to try to draw some broader truths and you have to and some how craft it in such a way that people will remember it and maybe change their practice. [[<Internals\Focus group transcripts\Group 1 Text 21apr09>](#)]

From Who to What

Probably one of the most frequent misconceptions that arose in the discussion with the participants, was the certainty that they and their colleagues had that the event and persons described in a CILS could be clearly identified; in particular that the CILS were about themselves, their unit or facility. As Cora put it, "Everybody. I know my staff at my other hospital would go through it and say okay these five are ours." [[<Internals\Focus group transcripts\Group 1 Text 21apr09>](#)] Describing a specific incident Andrea explained:

We had one that was recognizable on our ward and the way it was written up, kind of...not the way we would have wished it to have been. It kind of blamed the nurse. Not blamed the nurse, but didn't...but didn't convey how much communicated - he/she had done his/her job. He/She had communicated and was ignored. It didn't

quite...to our staff that was upsetting. [[<Internals\Focus group transcripts\Group 1 Text 21apr09>](#)]

However David felt he was not sure that given a set of CILS he would recognize a CI on which he had worked. So this remains an open question. Outside of this quality of human nature to identify personally with stories heard, and whether this is an accurate perception or not, the above quote by Andrea raises the issue of the risk of feeling exposed and blamed by the information in a CILS. But as Anne affirmed this is beginning to change:

Because [now] they also don't pass judgment. It's all of them learning. And this is happening somewhere here in Winnipeg [referring to a CILS event], and it could have happened to us. That's the direct care providers' perception now, where I think we come from generations of "*Don't tell anyone 'cause you're going to get in trouble.*" [[<Internals\Focus group transcripts\Group 2 Text 24apr09>](#)]

In both groups the overall consensus regarding the CILS was that the purpose of these - and the understanding of most people - is that these are for learning from error; and that this is far better than hiding or shrouding these events in secrecy. But most participants were clear that this comes with a risk; the risk that individuals will identify and feel blamed or victimized by the stories they read. As Bob related, '...that so again, people wanted to see...you know, "*Did anyone get raked over the coals?*" or "*Did he/she really mean what he/she said?*" [referring to the expectation of a non-blame environment surrounding the CI process and subsequent CILS] So I think that was part of the response.' [[<Internals\Focus group transcripts\Group 2 Text 24apr09>](#)] And Andrea provided the single reference in either focus group to an inequity of perceived blame between professions: "It kind of did let the doctor off the hook....And we kind of thought that by doing that you are kind of shifting the blame back to...[the nurse]." [[<Internals\Focus group transcripts\Group 1 Text 21apr09>](#)]

These comments then lead one to contemplate how the CILS are distributed and used within these seemingly suspicious and protective environments. Anne described how she shares CILS in team huddles and puts the minutes of these discussions into a book for reference, and then reflected that she hopes these are watered down enough for broad sharing. A few of the other participants echoed this concern about not knowing how broadly at their facilities the CILS can be made, or are available. Each group spent a fair bit of time in discussion of CIs; the CI process; issues of confidentiality of the CI reports; and about how system change is more apt to come from CIRC recommendations than from the CILS. Thus some effort went into differentiating the CI process and outcomes from the CILS. Unfortunately a similar confusion between the two processes likely exists beyond these focus groups and throughout the region; as Anne's comment genuinely expresses:

On the emails, write something like "*Everyone welcome to read.*" or something. Because honestly, I think some of the unit managers' thinking is that - I don't know - I don't know why they don't want to share them? Can't we just share this with everyone? But because on the email, it is specifically to..., say managers and directors. They think that maybe they shouldn't be sharing with others? I don't know "*...so maybe it's just for us to know and not to share*"...and if it said somewhere "*Ok to share with direct care providers*"...cause that was my sort of question. I said "*I got this email and I read it, and these are great. Can we just put them in a book?*"...and I kind of got the look of...um....So I think just a statement that clarifies that it's OK. That it's watered down enough. That no one is going to recognize anything. [[<Internals\Focus group transcripts\Group 2 Text 24apr09>](#)]

This is an important comment as directors and managers are apparently the main recipients of the CILS distributions. Indeed, the CILS carry a stern message of confidentiality that appears to be contradictory to the purpose of broad dissemination. David examined more than once his concern regarding what precisely is the message of the CILS:

So that my assumption is that the process, as it is currently constructed, doesn't appear to drive media reports or complaints and whatever. The general purpose should be to document and demonstrate to all concerned the media, the public, [and] healthcare workers that we're on this particular brief, we're thinking about it...and it would be particularly helpful if there was...if it was a little bit clearer how the system has changed as a result of these things. [[<Internals\Focus_group transcripts\Group 1 Text_21apr09>](#)]

I see it as a huge missed opportunity. And I've been talking about this since the whole CI process began. And all I get is "*Oh well yah, we sort of agree with you but maybe later on we will get to it*"...So I see this process [the CILS] as maybe trying to get to some of the deficiencies in this that have been raised, that multiply,...not just me but other people have raised all along. [[<Internals\Focus_group transcripts\Group 1 Text_21apr09>](#)]

Thus there are multiple expectations of the CILS. Some participants see the CILS as a dissemination of confidential and 'secret' knowledge similar to the heavily regulated CIRC reports, to be guarded and monitored; while David is looking for the depth of understanding and learning in how the investigation of a CI has resulted in concrete change. However David also challenged what he thinks is the direct purpose of the CILS and identified an area of knowledge dissemination he believes is not being addressed by either process:

So I don't think the purpose of the CILS is to change behavior. That has to be engineered at a different level. The purpose of the CILS is to keep safety issues in the forefront of peoples' minds and also to document and demonstrate to people that "*Hey we're doing something*". In that regard it might actually be more helpful to be much more particular and specific about how the system can be changed to make sure that this doesn't happen again. But, writing it down in a CILS isn't going to do that. Somebody has to redesign the anesthesia carts so that they can't make the mistake or redesign the resident training program so that making management plans is part of their final training...things to make sure they do it...or something that is very particular. [[<Internals\Focus_group transcripts\Group 1 Text_21apr09>](#)]

David seems to be promoting a process between the 'demonstration' function of the CILS and the creation of concrete change function of the CIRC. He hints further at what this might entail when he described what more he would like to see in the CILS. "So what I am trying to say is that the CILS is kind of one of the outputs of the patient safety process. How does this connect to the broader database of CIs and so [the] analysis of that?" [[<Internals\Focus_group transcripts\Group 1 Text_21apr09>](#)]

This feeling that there is a need for broader dissemination of statistical or other analysis of CIs is echoed by Brent as he situates the CILS in the context of health education:

As students progress through a program something like this [the CILS] would be less useful. I think bringing in the kinds of things that you talked about with a flow chart of stats. How common is this? How much of a worry is this kind of thing

within a systems perspective? [[<Internals\Focus group transcripts\Group 1 Text 21apr09>](#)]

And this is also echoed by Cora when she says that what might be needed is a note at the bottom of the CILS that identifies the incidence and prevalence of these events. Additionally some participants felt that what is needed by those working 'in the trenches' is more than statistical data but some higher level context; context that will situate the findings and recommendations for those readers who would like to make further use of the CILS, as here David clearly defines, "...what I see missing here is some kind of editorial content...[that is] trying to generalize and editorialize about the whole issue with selected little bits of information that might not have been made in the recommendations." [[<Internals\Focus group transcripts\Group 1 Text 21apr09>](#)]

This suggestion is not to belittle the CILS, as all participants were certainly on the promotion-side of the value of these. However there appears to be a gap between what is available in a CILS and what the participants saw as the real need of healthcare providers to learn about change in a fully informed and thoughtful manner. Who should be providing this context however is not necessarily the same issue as who should be enabling the direct healthcare providers to best benefit from the CILS.

Many of participants felt the CILS could be used to defuse some of the negative media sensationalism that haunts the CI process in Winnipeg. As Andrea tenuously proposed:

The critical incident, like all this stuff that has been in the news...the critical incident process hasn't really been explained, do you think, in the paper? Like they're all saying "*Oh well that was all pushed under the carpet and that people are hiding.*" Whereas we know with a critical incident what you say is protected. I don't know I don't feel the process has been...Like this [the CILS] would have been an opportunity to explain the process of a CI investigation to the public. [[<Internals\Focus group transcripts\Group 1 Text 21apr09>](#)]

This is in direct contradiction to the concerns of a few survey respondents who thought the CILS should not be distributed as this would harm public confidence in the healthcare system. Elaborating on this concern Bob described how he believes this perception originates with the media, who he also says is there to make a dollar on sensational stories:

I think media is the key keeper of that, and how they sensationalize and how they write about healthcare process. And you know I think they are...they are the key responsible people for making healthcare look the way we do. And certainly my experience with the public in general, even those who've experienced harm, is consistent with what's in the literature and 'how do we prevent this from happening with somebody else'....and I've really heard a lot of appreciation from the public. So I only think that negative...negativism comes from the media and them printing the stories in the manner that they do and in no way is that fair....Although I've heard it verbalized to me, and been thanked and appreciated and stuff for all our work, I've never seen that in print. And I know it's...I guess it's something that just doesn't make a story. [[<Internals\Focus group transcripts\Group 2 Text 24apr09>](#)]

Despite how healthcare is seen in the media, referring to the CILS David emphatically said, "I think that the only thing that anybody can conclude from reading these things is that the system is open and honest and trying to improve." [[<Internals\Focus group transcripts\Group 1 Text 21apr09>](#)] And despite feeling that the CILS are wonderful documents and greatly

appreciated, the participants did have many suggestions for improvement. As was clearly pointed out, it is important for recipients to understand that the CILS are meant to be distributed broadly; to spread the message that David articulated so well, "the system is open and honest and trying to improve" so adding a statement to the effect of "*Everyone welcome to read*" will complete this message.

Bob conveys frustration with obtaining further information about the issues raised in a CILS; mirroring David's desire to have more editorial content. Bob does not make explicit suggestions but identifies a different direction of responsibility. He wonders "how can this expert knowledge be accessed?" And to this point Bob ponders whether there might be a role for the RHAs in this. He does not offer an explicit solution but queries how this deeper level of knowledge can be accessed; much as David questions whether Patient Safety looks for patterns in the hundreds of CIs and if so how this information can be accessed. As Bob framed this:

...and sometimes when those of us in outlying health authorities, we might have a question you know. So you guys, you had a wound expertise in all regional facilities...like "*What does that look like?*" I have nobody to contact. I guess I could always...you know go through the system and find out, or track down who's in charge in long term care and stuff. But sometimes, when there's been modifications to processes or policies there's no connection. If we [his RHA] had something very similar to this [event from a CILS], what were the other learnings? I don't know if there could almost be a secondary level...or if that connects with the Regional Health Authorities in some way. [[<Internals\Focus group transcripts\Group 2 Text 24apr09>](#)]

Thus there is a desire to have the comprehensive CI findings and recommendations, and subsequent learning from implementation accessible both regionally and provincially. Some of this was the intent of the CILS distribution; although more limited in scope. However all participants voiced the reflection that these limitations impede the potential learning from the CILS, and the desire for more is great.

Learning from the CILS

Both Andrea and Brent agreed that staff find reassurance in the CILS. Anne said the CILS are a sign that the CI has been looked at, "...that it shouldn't happen again. That someone is taking the steps to make sure that the error was noted....it is reassuring to me." [[<Internals\Focus group transcripts\Group 1 Text 21apr09>](#)] Elaborating his academic perspective and summarizing the sentiment Brent said:

I would agree with that [Andrea's comment above] but also the fact that in the student world that these incidents are recognized and dealt with and recommendations are made and they're...they serve as very good learning experiences for the students; from an ethical point of view, from action point of view, from a number of points of view. I think that's what I like about them the most. So I agree with Andrea in terms of the fact that it's comforting to see that these kinds of things are not swept under the carpet as used to happen often. But they are public. [[<Internals\Focus group transcripts\Group 1 Text 21apr09>](#)]

Brent explained that the CILS have been integrated into the curriculum in both skills and theoretical courses in a way that allow the students to learn about the healthcare system and the kinds of decisions they will face there.

Andrea also said that the CILS are useful to stimulate discussion and that people do discuss them at work. "We discuss them at meetings....I mean they are interesting. They do sort of change your point of view..." [[Internals\Focus group transcripts\Group 1 Text_21apr09](#)] What she is unsure of is whether or not the CILS can promote concrete change. However changing the point of view of healthcare staff is no small matter. The argument could be made that such change will have broader and more lasting impact on the healthcare culture than any single, practical change implemented as a result of a recommendation. But then again, Anne describes how one CILS really hit home to her staff:

...and it changed everyone's practice. They're much better at being the two nurse check, and getting their pumps, and all that sort of stuff, which is ... if you can share any of those sorts of things that are very applicable to them they...rather than theoretical risks, they seem to integrate the knowledge better. Yes, it does change practice. [[Internals\Focus group transcripts\Group 2 Text_24apr09](#)]

David was emphatic that the purpose of the CILS is not behavioral change, and addressing the implications for learning he said, "I would say the same thing, that the process of CIs and the reviews result in change in practice. I'd like to think that we've already done that before the CILS gets there." [[Internals\Focus group transcripts\Group 1 Text_21apr09](#)]

And despite this he sees real opportunity for the CILS to educate and disseminate knowledge gained by the CIRC's. Each participant expressed in different ways that the opportunity of the CILS is in the as yet unrealized potential to provide a broader context of the meaning of the findings, and to relate the patterns or common findings of the CIRC's across multiple CIs.

Regarding this issue, of multiple CILS addressing the same type of event Cora concluded that, "The only learning that you can take from them is that this could happen to me too." [[Internals\Focus group transcripts\Group 1 Text_21apr09](#)] which is an important connection to make. As Cora said the CILS help raise awareness of what a CI is and, that since many staff do not recognize a CI as it is happening, the CILS help with that recognition and help the staff to be more comfortable reporting a CI when they do recognize one.

Cora is in an opportunistic position to learn from the CILS. As a CI investigator she can spot something of relevance to her in a CILS and access the other investigators directly for further insight into what was learned. This is important in her work as she does not want to 'reinvent the wheel'. "If they have already gone down this path I can just reinforce what has already been learned." [[Internals\Focus group transcripts\Group 1 Text_21apr09](#)] This sentiment, of not reinventing the wheel reasserts the need to develop an awareness of the common efforts in the region; and within the province.

Then along-side of reassurance is the 'Phew' factor. By focusing attention on the CILS event, awareness of one's own work may develop and similar risks can be examined. As David explained:

[That it is] because it's interesting to read about bad things that have happened in other programs and say "*Phew it didn't happen to us*"...or...and then mentally you try to say "*Well is there, is there some message in that that pertains to our practice?*" So we try to look at that. [[Internals\Focus group transcripts\Group 1 Text_21apr09](#)]

Distributed Learning

On the other hand, when the CI has happened on-site the learning is especially strong. As Anne described, "...people always take learning better when it has...this has happened here. Like if it has a direct implication, a direct reference to them personally, and they, the staff love them whenever we take a topic from one of those [CILS]." [[<Internals\Focus group transcripts\Group 2 Text 24apr09>](#)] And although it is not always verifiable that a certain CILS does come from a specific site, it seems that even the belief of a personal connection can have a beneficial influence. But if this effect is too important to people it may work against broad learning; as was pointed out a number of times not all CILS are directed to the care setting of the majority of providers. Then as the participants relate, the unit managers or program directors may only pay attention to those that have direct correlation to their work, and to their understanding of the needs and interests of their staff. And it was made clear that although some direct care staff have access to the CILS, most are not seeing them. As was pointed out, the drawback of this for the direct care provider is that they do not always work in only one setting, nor do they always stay in one type of setting. They are then not able to determine for themselves which CILS are most applicable to their work or interests.

How then to best disseminate knowledge is a difficult task, even when there is not legislation constraining what can be shared. As the CILS seem to point to the deep well of knowledge gained by the work of CIRC's David pondered:

What about all the learning [from CIRC's] that is given to the sites but not given to the program? Not given to standards and quality committees that might be...might contain details and information that can't go into the learning summary?" So what I've learned is that the learning summaries for clinicians that are trying to improve quality within a given program are way too watered down. [[<Internals\Focus group transcripts\Group 1 Text 21apr09>](#)]

However returning to David's other comment that the purpose of the CILS is not behavioral change; it may be that clinicians should not look to CILS for quality improvement but for culture change. Raising this concept Bob related his efforts at CILS distribution:

...I might have...you know, ruffled a few feathers. But that's my job if I'm going to change the culture, if we're going to get things out there. And I had no qualms about distributing to whoever, and I'd certainly take any responsibility that came with that. [[<Internals\Focus group transcripts\Group 2 Text 24apr09>](#)]

But efforts at culture change should not let the Patient Safety Team 'off the hook' for further efforts at disseminating the knowledge gained. Apparently a gap exists between sites and programs, committees and PS efforts. Although the CILS are not seen as a method to close this gap, these may promote the change of perspectives required to find the best method to do this. Bob expressed both sympathy and frustration for the difficulties involved in patient safety efforts:

...we're working on it and really decrease the harm that comes to patients. And that's our ultimate goal. And we haven't been able to prove that yet. We don't have resilient processes that will guarantee no harm. And I don't know even if, in the healthcare system, that's even a realistic goal for us. I mean...we just...nothing is standardized; every department runs differently, we've got different systems in every place, and people educated in different backgrounds and different schools.

You know? And though we strive for that, is it achievable? I sure hope it is. But I don't know how. [[<Internals\Focus group transcripts\Group 2 Text 24apr09>](#)]

The overall sentiment of the participants was that the CILS are an important tool for 'homegrown' learning about our own healthcare system. The following exchange between Anne and Bob exemplifies this common understanding:

Anne - I hope they continue. I think they're a wonderful learning tool. And I know that the staff...as I've said before...really like the realness of them and the proximity to them. It's not about something that...you know...happened in Brazil. It's something that happened at a sister hospital, or to a colleague, so...and I think that we're changing things. "Let's learn from what they learned", not....

Bob - Not re-experience it.

Anne - Exactly. The definition of..."*You don't live long enough to make all the mistakes yourself. Please learn from the mistakes of others.*" [[<Internals\Focus group transcripts\Group 2 Text 24apr09>](#)]

Synopsis of Suggestions

"If it's a general problem then do we have a remedy? Not easy. I've been at this a long time. It ain't getting any better than it was twenty years ago. I'm not sure how to remedy it."

[[<Internals\Focus group transcripts\Group 1 Text 21apr09>](#)] Despite David's pessimism in this statement the participants were quite enthusiastic about the CILS and contributed many suggestions for improvements.

- One suggestion not previously presented and which all participants supported is to not wait six to eight months to send a whole bunch out. However to be fair there was not a new set of CILS for this lengthy period of time while this assessment was being conducted! But a moot point, as all participants were emphatic that what is needed are groups of three or four CILS sent out every two to three months. Sending these out seasonally and tagging them as such was promoted as a way to help people recognize which sets they have seen previously. Classifying each by type of CI and date was suggested however this is already the case; along with the suggestion that the CILS are sent out as separable PDF documents.
- The suggestions provided around how to tell the story of the CI were more comprehensive, varied and detailed. Patient Safety should try to add fictional content to 'spin' the story with more detail or 'grabbers'. Thus the suggestion is to write in a style which will have maximum impact. The context of the stories must also draw on broader truths while clearly identifying where the breakdown occurred. By explaining more clearly what needs to be changed, telling the story with impact and situating this in a broader context it was considered that a reader will want to make this change in their practice.
- It could not have been any clearer that the message of "EVERYONE IS WELCOME TO READ THIS" needs to be made more assertively. In particular it was suggested this be on each individual CILS; for although this is included in each email and attached cover letter it became obvious in both the survey and the focus groups that this message was not propagated through the system. Important learning opportunities may be lost if the selection of CILS for distribution to direct care providers in a specific setting is based

only on their relevance to that area. Many direct care providers regularly circulate through a variety of work settings thus other CILS (not selected for distribution) may also be equally relevant to their practice. Therefore, it should be encouraged for all CILS to be distributed to direct care providers.

- Similar to the details suggested for a story telling model, there is a desire for details that situate the CI in broader context of the WRHA (or even within Manitoba). Related to this is the wish to have relevant statistics of the type of incident described and any other analysis, systemic patterns or other information that the CIRC process has uncovered or discovered through their investigation.
- Possibly more easily accomplished it was suggested that the incidence and/or prevalence of the specific CI be provided as a line at the bottom of the CILS.
- And regardless of whether or not a semi-fiction story is to be told it was suggested that the findings and recommendations as they are currently presented require more editorial context that will generalize what can be learned from the CILS.
- It was also suggested that a way for providers looking to understand better and make changes where they work requires a way to access the expert knowledge that either informs or results from the CIRC. Related to this is the request for more statistical and research information and that there be a way for RHAs to share knowledge. This kind of knowledge gained from CIs, within a broader context, should also be made available to programs, committees, etc.
- The last suggestion here is to educate the public better about the process and the goals of the Critical Incident Review Committees.

APPENDICES

Appendix A: WRHA cover letter & Critical Incident Learning Summary example



Winnipeg Regional Health Authority
Office régional de la santé de Winnipeg
Caring for Health À l'écoute de notre santé

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March 31, 2008

Re: Critical Incident Learning Summary (CILS) Distribution

I am pleased to provide you with the first group of WRHA Patient Safety Critical Incident Learning Summaries (CILS).

A CILS is created for selected events once a Critical Incident Review Committee (CIRC) has completed the review and analysis of a critical incident (CI). The method used by the WRHA to analyze critical incidents (New Lens) is an adaptation of the London Protocol, which attempts to control, as much as possible for hindsight bias. We strive to identify as many of the key contributing factors that led to the particular event being reviewed. The recommendations in the final report reflect an attempt to modify these factors so as to reduce the likelihood that similar events will recur in the future. CILS are created for CIs where the learning potential goes beyond the scope of the reviewed event. The information provided in a CILS is based on the final report prepared by the CIRC at the completion of the review. Only those recommendations with systemic learning potential are included in the CILS.

This first grouping includes a selection of CILS from the following five categories: Transition, Diagnosis, Infection, Fall, and Medication. Of note, a link amongst the three Medication CILS is the administration of a paralytic agent (atracurium) instead of a relaxant (midazolam) in ambulatory surgical facilities within WRHA. These three events have led to significant re-design efforts by the Regional Anaesthesia Program.

Our goal is to facilitate broader learning by providers and facilities throughout the healthcare system. While Patient Safety receives several hundred CI reports each year, we anticipate that you will receive approximately 100-150 CILS each year in periodic distributions. Please feel free to pass these CILS along to other individuals/groups that may be interested, or contact Patient Safety at (204) 926-8058 to add their names to our distribution list. Your feedback is also welcome, please let Patient Safety know if the CILS have been useful in transferring the knowledge gained through these CI reviews into current practices within your facility/site/setting. You can reach us at CILS@wrha.mb.ca

A handwritten signature in black ink, appearing to read 'Rob Robson'.

Dr. Rob Robson
Chief Patient Safety Officer
WRHA



Critical Incident Learning Summary

February 2008

Critical Incident Category: Medication

What happened?

A patient slated for surgery was being prepped for a spinal anesthetic. Following administration of the medication, the patient suddenly flopped back down to a supine position, began twitching, and was unresponsive to commands. Respirations ceased and the patient was intubated for airway protection. It was thought that the patient might be having a seizure so an additional dose of the medication was given. En route to ICU, the patient rapidly (within 1-2 minutes) became alert and responsive, moving all limbs in response to command. Following extubation, the patient reported that the earlier twitching was an attempt to move. Urine and drug screens for muscle relaxants were sent. The patient was discharged back to the ward and then home the next day. The lab confirmed the presence of a muscle relaxant metabolite in the patient's urine. It was concluded that the patient had inadvertently received a muscle relaxant medication (Atracurium) instead of a sedative (Midazolam) in the OR.

What were the review findings?

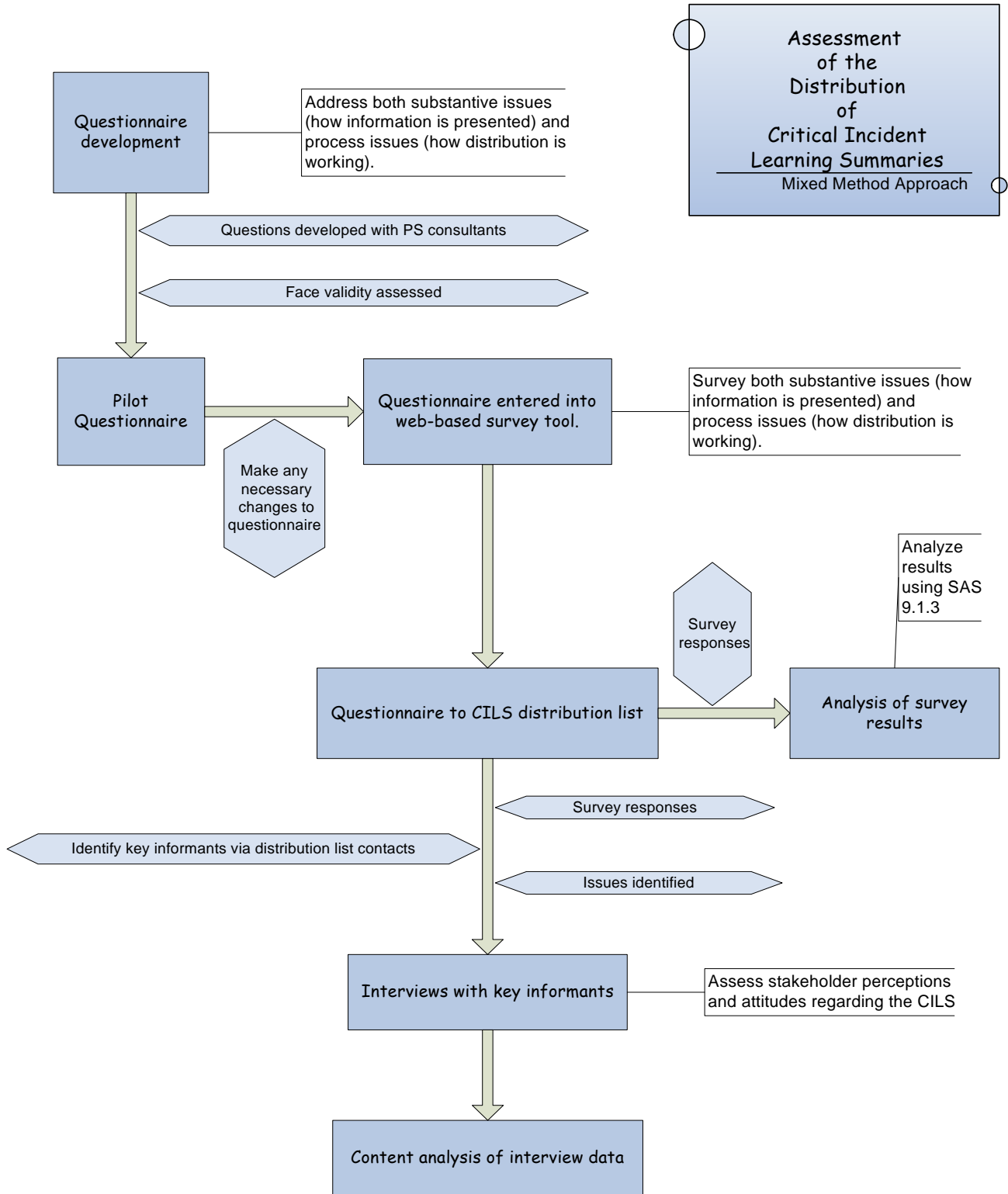
- Midazolam and Atracurium were on the Anesthetist's workspace on the Anesthesia Cart because there was no place to store Atracurium other than in the fridge.
- Design and usage of Anesthesia cart can create a cluttered workspace thus increasing risk of error.
- Atracurium was inadvertently administered to a patient during a spinal anesthetic instead of Midazolam

What was recommended?

- Standardize the anesthesia carts and trays in order to minimize the risk of this type of error. The standardization process should consider the following: contents and layouts of carts and trays, as well as labeling of drugs, equipment and supplies (including user-applied labels).
- Involve the appropriate Program personnel in the procurement process for anesthetic drugs, equipment and supplies. This is needed to ensure that once standardized, the contents of anesthesia carts and trays remain standard or, when this is not possible, that the Anesthesia Program has input into selecting new items and ensuring that the end-users (i.e. anesthetists) are notified.

THIS REPORT HAS BEEN PREPARED AT THE DIRECTION OF THE WRHA PATIENT SAFETY AND QUALITY RESEARCH COMMITTEE AND IS PRIVILEGED UNDER SECTION 9 OF THE MANITOBA EVIDENCE ACT. IT HAS BEEN ABSTRACTED FROM AN ACTUAL CRITICAL INCIDENT REVIEW, BUT IDENTIFYING INFORMATION HAS BEEN REMOVED OR MODIFIED IN ORDER TO CIRCULATE TO HEALTH CARE PROVIDERS AND ORGANIZATIONS TO PROMOTE LEARNING FROM CRITICAL INCIDENTS.

Appendix B: Process map of research methods



Appendix C: Paper copy of survey

This survey asks questions and makes statements for your response regarding the distribution, content, and purpose of the Critical Incident Learning Summaries (CILS, described below).

TIME TO COMPLETE: The survey will take approximately three to seven minutes to complete.

PRIVACY AND CONFIDENTIALITY: All the information you provide will be kept secure and confidential. Any identifying information you provide in this survey regarding individuals will be de-identified before analysis and reporting.

You are under no obligation to complete this survey.

Upon completion of the project report, presentations, and possible publication the data you provide here will be destroyed. Until then all this data will be securely stored within a password protected or locked environment.

FURTHER CONTACT: We would like to contact some of the respondents for participation in a focus group regarding the CILS. If you are interested in being a possible candidate for this, please complete the **optional** contact information at the end of this survey. Your contact information will be used exclusively for arranging the focus group. At no point will any of the survey respondents' names, titles, or contact information be identified in any analysis or resulting report.

This survey is part of the **Assessment of the Distribution of Critical Incident Learning Summaries Project** which received the Manitoba Institute of Patient Safety's John Wade Research Award.

Barb Freed (WRHA Critical Incident Coordinator) and Elaine Pelletier (WRHA Patient Safety Process Analyst) are co-principal investigators on this project. Dr. Rob Robson (WRHA Chief Patient Safety Officer) and Marilyn Kilpatrick (WRHA Director of Operations Patient Safety) are co-investigators.

If you would like to contact the principal investigators regarding this project please email either bfreed1@wrha.mb.ca or epelletier@wrha.mb.ca.

CRITICAL INCIDENT LEARNING SUMMARIES

The Winnipeg Regional Health Authority Patient Safety Team has distributed three sets of Critical Incident Learning Summaries (CILS). CILS are created for selected events once a Critical Incident Review Committee (CIRC) has completed the investigation/review and analysis of a Critical Incident (CI).

CILS are created for CIs where the learning potential goes beyond the scope of the reviewed event and only those recommendations with systemic learning potential are included in the CILS. Because the review of CIs in Manitoba is legally protected under the Manitoba Evidence Act, the CILS necessarily are significantly de-identified. We strive to provide enough information to stimulate learning in other units, facilities and regions across the country, while respecting the duty of confidentiality.

Thank you for reading this information. Now please continue to the survey!

1. Have you seen, read, or discussed any of the Critical Incident Learning Summaries?

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

2. Are you aware of the WRHA Critical Incident Reporting and Support Line (788-8222)?

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

3. Do you work in a healthcare setting?

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

4. If you have not seen, read or discussed any of the CILS we thank you for completing this part of the survey. We do not require any further information from you but if there are any related comments you would like to make please do so below.

General Comment:

If you have seen, read or discussed any of the CILS please complete the remaining part of the survey.

5. In what type of setting do you work?

<input type="checkbox"/>	Acute Care
<input type="checkbox"/>	Personal Care Home
<input type="checkbox"/>	Long Term Care
<input type="checkbox"/>	Community Healthcare
<input type="checkbox"/>	Other (please specify):

6. Do you provide direct or indirect health care?

<input type="checkbox"/>	Direct Care: [Direct care is by a caregiver who provides hands-on care to a patient, client, or resident.]
<input type="checkbox"/>	Indirect Care: [Indirect care is by persons who provide administrative or other support to the healthcare facility, site or program. This care does not involve hands-on care of a patient, client, or resident.]

Please check which main type of role you have in the healthcare system.

7a. Direct Care

<input type="checkbox"/>	Allied Healthcare: [A healthcare professional, for example a physiotherapist, occupational therapist, recreation therapist, pharmacist, social worker, dietician.]
<input type="checkbox"/>	Healthcare Aid
<input type="checkbox"/>	Nurse
<input type="checkbox"/>	Pharmacist
<input type="checkbox"/>	Physician
<input type="checkbox"/>	Other (please specify):

7b. Indirect Care

<input type="checkbox"/>	Administrator
<input type="checkbox"/>	Analyst
<input type="checkbox"/>	Clerical
<input type="checkbox"/>	Consultant
<input type="checkbox"/>	Director
<input type="checkbox"/>	Educator

<input type="checkbox"/>	Food Service
<input type="checkbox"/>	Maintenance
<input type="checkbox"/>	Manager
<input type="checkbox"/>	Pharmacist
<input type="checkbox"/>	Other (please specify):

8. Please note where you work:

<input type="checkbox"/>	In the Winnipeg Region
<input type="checkbox"/>	Outside the Winnipeg Region but in Manitoba
<input type="checkbox"/>	Outside Manitoba

9. How did you first hear about the Critical Incident Learning Summaries?

<input type="checkbox"/>	Colleague
<input type="checkbox"/>	Communication book
<input type="checkbox"/>	Email
<input type="checkbox"/>	Media
<input type="checkbox"/>	Posted in area accessible to the public
<input type="checkbox"/>	Posted on unit
<input type="checkbox"/>	Supervisor
<input type="checkbox"/>	Website
<input type="checkbox"/>	Other (please specify):

10. Please check all locations where you have seen the CILS posted.

<input type="checkbox"/>	Communication book
<input type="checkbox"/>	Have not seen these posted
<input type="checkbox"/>	Media
<input type="checkbox"/>	Posted on unit
<input type="checkbox"/>	Website
<input type="checkbox"/>	Other (please specify):

11. In what format did you view the CILS?

<input type="checkbox"/>	Electronic copy
<input type="checkbox"/>	Paper copy
<input type="checkbox"/>	Haven't seen one yet!

There have been three sets of CILS distributed (10-13 CILS per set).

12. Did you read the complete set of CILS or only specific ones?

	Complete set	Specific ones	Not sure which ones I saw	Not sure which ones I read	Only heard about the CILS
Set 1					
Set 2					
Set 3					

13. Did you see any of the cover letters that go out with each set of CILS?

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

14a. Direct Care: Have you experienced the CILS being used in any of these ways:

<input type="checkbox"/>	At staff meetings
<input type="checkbox"/>	At rounds
<input type="checkbox"/>	At other educational sessions
<input type="checkbox"/>	Other (please specify):

14b. Indirect Care: To your knowledge have the CILS been used in any of these ways:

<input type="checkbox"/>	Rounds
<input type="checkbox"/>	Other Educational Sessions
<input type="checkbox"/>	Staff Meetings
<input type="checkbox"/>	Other (please specify):

PLEASE CHECK THE BOX THAT YOU FEEL BEST REPRESENTS YOUR AGREEMENT OR DISAGREEMENT WITH EACH OF THE FOLLOWING STATEMENTS:

15. The content of the CILS is easy to understand.

<input type="checkbox"/>	Strongly Agree
<input type="checkbox"/>	Mostly Agree
<input type="checkbox"/>	Unsure
<input type="checkbox"/>	Mostly Disagree
<input type="checkbox"/>	Strongly Disagree

16. The purpose of distributing this kind of information is easy to understand.

<input type="checkbox"/>	Strongly Agree
<input type="checkbox"/>	Mostly Agree
<input type="checkbox"/>	Unsure
<input type="checkbox"/>	Mostly Disagree
<input type="checkbox"/>	Strongly Disagree

17. The CILS are informative.

<input type="checkbox"/>	Strongly Agree
<input type="checkbox"/>	Mostly Agree
<input type="checkbox"/>	Unsure
<input type="checkbox"/>	Mostly Disagree
<input type="checkbox"/>	Strongly Disagree

18. The CILS contain enough information for me to better understand these unintended events, which may occur when healthcare services are provided.

<input type="checkbox"/>	Strongly Agree
<input type="checkbox"/>	Mostly Agree
<input type="checkbox"/>	Unsure
<input type="checkbox"/>	Mostly Disagree
<input type="checkbox"/>	Strongly Disagree

19. The CILS contain enough information for me to better understand how the Winnipeg Regional Health Authority intends to learn from critical incidents.

- Strongly Agree
- Mostly Agree
- Unsure
- Mostly Disagree
- Strongly Disagree

20. The CILS contain applicable information for learning in my own area of work/practice.

- Strongly Agree
- Mostly Agree
- Unsure
- Mostly Disagree
- Strongly Disagree

21. I recommend for others to read the CILS.

- Strongly Agree
- Mostly Agree
- Unsure
- Mostly Disagree
- Strongly Disagree

22a. Direct Care: Reading a CILS is an incentive for me to report a potential critical incident.

- Strongly Agree
- Mostly Agree
- Unsure
- Mostly Disagree
- Strongly Disagree

22b. Indirect Care: I think that the story told in a CILS would be an incentive for a direct care provider to report a potential critical incident.

- Strongly Agree
- Mostly Agree
- Unsure
- Mostly Disagree
- Strongly Disagree

23. Distributing the CILS will help the healthcare system to reduce preventable harm to patients.

- Strongly Agree
- Mostly Agree
- Unsure
- Mostly Disagree
- Strongly Disagree

Optional Contact Information:

We would like to conduct focus groups for in depth understanding of the information provided in the survey. If you are interested in being considered for one of these focus groups please provide your contact information below.

Name	
Title/Role	
Site/Setting	
Phone Number	

If there is time of day or alternate number contact information please provide this here.

--

If you would prefer contact through email please enter this here.

Email Address:	
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If you have any additional comments on, or questions about the CILS please tell us on the back of this page.

Thank you for completing our survey!

We appreciate the time you have taken to provide us with this important feedback for our assessment.

Appendix D: Focus Group Consent Form

Consent Form Version 1 Date: Date, 200#

Title: Focus Group with Health Care Workers on Critical Incident Learning Summaries

Focus Group Facilitator: Gail Marchessault, Ph.D., PHEc, R.D.
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Principal Investigators:

Elaine Pelletier MSc, BSc (Statistics)
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BFreed1@wrha.mb.ca

What are some general things you should know about participating in a focus group?

You are being asked to take part in a focus group. To do so is voluntary. You may refuse to join, or you may withdraw your consent to participate, for any reason, without penalty.

Details about this focus group are discussed below. It is important that you understand this information so that you can make an informed choice about participating. You will be given a copy of this consent form. You can ask any questions about this focus group before, during, or after the focus group.

What is the purpose of this focus group? The purpose of this group is to learn more about the perceptions of the recipients of the Critical Incident Learning Summaries (CILS) which have been distributed by WRHA Patient Safety over 2008. Perceptions of the CILS usefulness in healthcare settings is of specific interest however assessment of the distribution of the CILS is also of interest.

How many people will take part? Twenty-five to 35 people will participate in a focus group or individual interview on this topic. Participants were recruited through an on-line and paper survey conducted by the WRHA Patient Safety Team.

How long will your part in this focus group last? The focus group will last approximately 1 ½ hours.

What will happen during the focus group? The group will be asked to discuss what they know about CILS and what they'd like to have more information about. No questions will be directed to you individually, but instead will be posed to the group. You may choose to respond or not respond at any point during the discussion. The focus group discussion will be audio-taped. A voice recorder is used to assist the focus group moderator to remember what participants said which will assist a more thorough analysis. The recording will be transcribed and analyzed by the moderator and the Principal Investigators. Quotes may be used in written

and/or oral reports of the findings. No names or identifying features will be included in the transcripts or any subsequent reports.

What are the possible benefits from being in this focus group? You may not benefit personally from being in this focus group. Results may be used to revise the content, development, and distribution of the CILS. Any new knowledge gained may be shared through written and/or oral reports. A presentation poster will be created for sharing the findings.

What are the possible risks or discomforts involved from being in this focus group? We do not anticipate any risks or discomfort to you from participating in this focus group. Even though we will emphasize to all participants that comments made during the focus group session should be kept confidential, it is possible that participants may repeat comments outside of the group at some time in the future. Therefore, we encourage you to be as honest and open as you can, but remain aware of our limits in protecting confidentiality.

How will your privacy be protected? Every effort will be taken to protect your identity as a participant in this focus group. You will not be identified in any report or publication of findings. Your name will not appear anywhere. After the focus group results have been analyzed, the audio-tape will be erased. Focus group members will be asked not to repeat anyone's comments outside of the room.

Will you receive anything for your participation? There is no compensation for taking part in the focus group.

Will it cost you anything to participate? There will be no costs for being in the study

What if you have questions? You have the right to ask, and have answered, any questions you may have about this project. If you have questions or concerns, contact Gail Marchessault at 774-4637. You can also contact Elaine Pelletier at 926-7110 or Barb Freed at 926-8077.

Consent Form – Focus Group with Health Care Workers on Critical Incident Learning Summaries

I agree to take part in the focus group project specified above. I have had the project explained to me, and I have read the Explanatory Statement, and been given a copy for my records. I understand that agreeing to take part means that:

1. I agree to involved in a focus group
2. I agree to allowing the focus group to be audio-taped

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.

I understand that any data extracted from the focus group for use in reports or published findings will not contain names or identifying characteristics.

I have been given the opportunity to ask any questions I wish regarding this project. I understand that if I have any additional questions I may call Gail Marchessault at 774-4637 or Elaine Pelletier at 926-7110 or Barb Freed at 926-8077.

Participant's name _____

Signature _____

Date _____

I, the undersigned, have fully explained the relevant details of this project to the participant named above and believe that the participant has understood and has knowingly given their consent to be contacted.

Focus Group Moderator's name _____ Gail Marchessault _____

Signature _____

Date _____