

To err is human, but to fail to learn is inexcusable.

Sir Liam Donaldson, former chief medical officer, Department of Health, United Kingdom, and chair of the World Health Organization World Alliance for Patient Safety. Keynote address at the launch of the alliance in Washington, D.C.

National System for Incident Reporting

NSIR



## Collect. Analyze. Share. Learn.



Welcome to the quarterly National System for Incident Reporting (NSIR) electronic bulletin. This is where you can find information on medication and radiation treatment incident reporting and analysis for sharing and learning across Canada.

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## Inside this issue

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- [ISMP Canada's recent alerts and safety bulletins](#)
- [NSIR's family tree is growing!](#)

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- [NSIR-RT incidents with problem type "other"](#)

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## Sharing critical incidents for learning and prevention

In NSIR, critical incidents include those that have an outcome of severe harm, as defined previously, or death. When incidents like the aforementioned case scenario are submitted to NSIR with harm coded as none, mild or moderate, they are not identified as a critical incident.

The outcome to the patient in the case example could very well have been brain damage or even death, had it not been for the life-saving intervention. Using NSIR's definitions, a critical incident occurred. The basis of our work at NSIR is to analyze these kinds of incidents, understand trends and patterns, and provide information to NSIR users and partners about these incidents.

## Critical incidents submitted to NSIR

Between 2008 and early 2019, 207 critical incidents were reported to NSIR from 87 facilities across Canada.

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Of all critical incidents reported to date, 24% of critical incidents did not report a problem type and were coded as “other” compared with only 15% of non-critical incidents. Problem type is a core data element that is often used as a filter to explore NSIR data.

Other problem types for critical incidents include wrong quantity (24%), wrong product (12%), wrong rate/frequency (11%) and omitted dose (9%).

Some users find it challenging to select a single problem type and feel that more than one may have contributed to the incident. In these cases, we ask that users select the problem type most responsible for the harm instead of



# Additional information

## Upcoming conferences and learning



### [Public Health 2019](#)

April 30 to May 2, Ottawa

Public Health 2019 is the national forum where public health professionals, researchers, policy-makers, academics, students and trainees come together to strengthen efforts to improve health and well-being, to share the latest research and information, to promote best practices and to advocate for public health issues and policies grounded in research.

### [2019 CAHSPR Scientific Conference](#)

May 29 to 31, Halifax

What really happens when research meets policy? Get the inside scoop at the 2019 CAHSPR Scientific Conference from May 29 to 31 in Halifax. Health care leaders from Nova Scotia and across Canada will talk openly about what they value in health services research and hear noted researchers explain how they make their findings helpful to decision-makers.

### [e-Health 2019 Conference and Tradeshow](#)

May 26 to 29, Toronto

The annual e-Health Conference and Tradeshow is the biggest event to bring Canadian digital health professionals together to network, connect and learn from one another. The Canadian Institute for Health Information (CIHI) is excited to co-host this event, and we're planning multiple presentations that you'll definitely want to see.

### [RTi3: Radiation Therapy Conference](#)

May 31 to June 1, Toronto

RTi3 is Canada's premier annual meeting for the radiation therapy community. RTi3 is committed to advancing the science and practice of radiation therapy, showcasing the latest research and clinical innovations.

### [PxP2019 Conference](#)

June 3 to 5, Toronto

The Canadian Pharmacists Association (CPhA) and the Ontario Pharmacists Association (OPA) announce Pharmacy Experience Pharmacie (PxP).

The inaugural PxP2019 replaces CPhA's and OPA's individual conferences. At this national gathering, the entire pharmacy community can come together to learn, connect and be inspired about pharmacy as a profession, a practice and a calling.

### [ISMP Canada Med Safety Exchange webinar series](#)

May 15, 2019 and July 17, 2019

Join your colleagues across Canada for ISMP Canada's complimentary bimonthly 50-minute webinars, where professionals share, learn and discuss incident reports, as well as trends and emerging issues in medication safety.

To register and for more information on this series, please visit [ISMP Canada — Med Safety Exchange](#).

## Recent CIHI releases

### [Patient Experience in Canadian Hospitals](#)

April 17, 2019

Starting this spring, CIHI will begin publicly reporting on patient experiences collected through the Canadian Patient Experiences Reporting System.

## Contact us



Thank you for taking the time to read the NSIR eBulletin. Unless otherwise stated, the reported NSIR findings are based on the voluntary reporting of incidents at participating health care facilities across Canada. If there is anything you would like to see featured in an upcoming edition, please email us at [nsir@cihi.ca](mailto:nsir@cihi.ca).

The NSIR eBulletin is distributed on a quarterly basis. Previous editions can be found at [NSIR](#).

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## References

1. ISMP Canada. [Summary of 2015 critical incident reporting analysis](#). *Ontario Critical Incident Learning*. July 2016.
2. Mahajan RP. [Critical incident reporting and learning](#). *British Journal of Anaesthesia*. July 2010.