	Department of Health Government of Nunavut	**NURSING POLICY, PROCEDURE AND PROTOCOLS** Community Health Nursing	
TITLE:		**SECTION:**	**POLICY NUMBER:**
Client Safety Event – Screening for and Conducting Incident Analysis		Administration	05-036-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
July 12, 2022	July 12, 2025	NEW	11
APPLIES TO:			
All Department of Health Staff (Community Health Centre and Iqaluit Health Services Providers)			

1. BACKGROUND:

The Department of Health (Health) is committed to delivering safe and quality care for Nunavummiut. In addition to supporting client and family needs, timely notification, review, and management of harmful incidents are key activities to reducing preventable harm and improving quality of care for Nunavummiut.

Harm and errors in healthcare almost always occur due to complex system interactions involved in delivering care. Incident reporting is a **non-punitive** learning process which provides frontline staff with the ability to identify system and organizational constructs that may lead to undesirable outcomes. All staff play a critical role in identifying and reporting incidents and contributing to a learning culture to understand what happened, how and why it happened, and how it can be prevented from happening again.

2. POLICY:

2.1 All client safety incidents categorized as severity level 5 and 6, or identified as never events will receive a Critical Incident Urgent Teleconference (CIUT) to determine the need for further action and review.

2.1.1 All client safety incidents categorized as severity level 4 will be screened for the necessity of a CIUT.

2.2 The incident analysis process shall be initiated within 48 hours of the incident report being received. Final reports will receive approval by the Quality Improvement Committee and additional parties, as required.

2.3 The immediate supervisor and staff shall provide support to clients and families throughout the critical incident analysis process. The immediate supervisor will offer the opportunity for clients and families to participate in the review process, including follow-up on the analysis findings.

2.4 The immediate supervisor and/or Director shall provide support to staff throughout the critical incident analysis process. Additional resources may be offered (e.g., Employee and Family Assistance Program 24/7 Hotline: 1-800-663-1142).

2.5 Following incident analysis, the immediate supervisor and/or Director shall share learnings with involved staff, client/family, other practice areas, and the organization, as appropriate.

3. PRINCIPLES:

3.1 This policy aligns with the following Inuit Qaujimajatuqarigit Principles:

i. *Tunnaganarniq*, fostering good spirits by being open, welcoming and inclusive;
ii. *Inuuqatigiitsiarniq*, respecting others, relationships and caring for people;
iii. *Piliriqatigiinniq*, working together for a common cause, and more specifically, for the health and safety of clients of the Department of Health;
iv. *Pilimmakasarniq/Pijariuqsarniq,* development of skills through practices, effort, and action.

3.2 Clients, visitors, and staff have the right to a safe environment in which to receive care, visit, and work.

3.3 Health actively supports a workplace environment rooted in just culture. A just culture ensures that staff feel comfortable, safe, and encouraged to report quality and safety concerns because there is trust that a fair and consistent approach will be applied when reviewing and responding to unexpected events. This includes:

i. Fostering an environment of support and safety for staff;
ii. Ensuring that reports are reviewed in a non-judgmental, consistent, fair, and supportive manner, utilizing a systems thinking approach; and
iii. Supporting individual and organizational learning by providing the opportunity to discuss safety incidents, review contributing factors, and determine how to reduce the risk of recurrence.

3.4 Incident reporting is a non-punitive learning process that increases safety for clients, visitors, and staff and informs quality improvement initiatives.

3.5 The Government of Nunavut (GN) has mandated responsibilities under the *Workers Safety and Compensation Commission Act* (WSCC) and the *Safety Act* for Nunavut to protect the health and safety of its clients, visitors, and staff.

4. DEFINITIONS:

Client: a person who receives health services.

Clinician: a person who provides health services for Health either as an employee or a contractor, including physicians. The term 'staff' is inclusive of clinicians in this policy.

Critical Incident: An unintended event or circumstance that occurs when a client's interaction with the health system results in severe harm or death and does not result primarily from the client's underlying medical condition, or from a known risk of treatment.

Harm: An unexpected or normally avoidable outcome that:

i. Negatively affects a client's health or quality of life;
ii. Occurs or occurred during the course of health care treatment; and
iii. Is not directly due to the client's underlying illness.

Harm implies impairment of structure or function of the body and/or any deleterious effect arising there from, including disease, suffering, disability, and death. Harm may be physical, social, or psychological.

Immediate Supervisor: The staff member to whom you report (e.g., Supervisor of Health Centre (SHP), Regional Manager, or Director of Health Programs (Director).

Incident: An unintended event or circumstance which could have resulted, or did result, in unnecessary and/or unintended harm to the client. This includes near miss, no harm, and harmful events.

Incident Report: A written report describing the factual elements of an incident. Incident reports provide valuable data that are used to identify local, regional, and territorial trends. Incident reports inform policy and health system changes to improve client and staff safety. These reports are confidential and are not a part of the client's medical record nor the clinician's file.

Just Culture: An organizational approach which balances the need for staff to act safely with the responsibility of a responsive, safe system. A just culture ensures that staff feel comfortable, safe, and encouraged to report quality and safety concerns because there is trust that a fair and consistent approach will be applied when reviewing and responding to unexpected events.

Never Event: A subset of serious adverse clinical events. These incidents are considered critical regardless of the client outcome. Never Events have known mitigation strategies that, when appropriately implemented, would prevent the occurrence of the event. See Appendix A: Never Events and Urgent Teleconference Criteria.

Systems Thinking: An approach which focuses on the conditions under which people work (i.e., the system), rather than on the individual. Systems thinking in healthcare emphasizes that client safety incidents typically occur due to system failures.

5. PROCEDURE

Refer to *Policy 05-034-00 Client Safety Event – Incident Reporting and Immediate Management* for information regarding the immediate response to client safety incidents.

5.1 Screening Client Safety Incident for Analysis

5.1.1 After a client safety event occurs, the Chief Nursing Officer and Chief of Staff are responsible for determining if a CIUT is required.

i. See **Appendix A: Never Events and Urgent Teleconference Criteria;**

ii. See **Appendix B: Urgent Teleconference Template**

iii. If an incident has resulted in unexpected and/or unintended moderate harm (severity level 4), the event will be screened for the necessity of an CIUT.

iv. If an incident has resulted in unexpected and/or unintended severe harm or death (severity level 5 or 6), or is classified as a never event, a CIUT is required to determine the need for further action and review.

5.1.2 CIUT's are to be held within 48 hours of an incident occurring. When an incident occurs on a non-business day, the CIUT shall occur as soon as reasonably possible.

5.1.3 To prepare for the CIUT, the immediate supervisor and/or the Director shall:

i. Gather information (e.g., relevant policies, incident report, client medical record) to obtain a preliminary understanding of what occurred;

ii. Speak with involved staff to understand what happened;

iii. Refer to the appropriate manager, if input is required;

iv. Develop a written timeline using the information gathered.

5.1.4 The Quality Team is responsible for coordinating and facilitating CIUTs.

5.1.5 The decision to conduct further review of an incident shall be made collectively during the CIUT.

5.1.6 Upon the decision to conduct further review, the following information is required:

i. Type of analysis: **Appendix C: Criteria for Selecting a Method of Incident Analysis** shall be used, along with contextual information, to determine which method of analysis is most appropriate

ii. Analysis Chair (individual accountable for the completion of the review)

iii. Analysis Lead (individual responsible for the completion of all activities)

iv. Analysis Team

v. Additional action items

5.1.7 If a CIUT is deemed not necessary, the immediate supervisor is responsible for ensuring

the completion of local actions to manage the incident.

5.2 **Conducting Incident Analysis of a Client Safety Incident**

5.2.1 Analyses must be completed as soon as reasonably possible;

5.2.2 The Analysis Chair is accountable for the completion of all analysis activities;

5.2.3 The Analysis Lead is responsible for the completion of all analysis activities;

5.2.4 The Analysis Team is responsible for contributing to the development of findings and recommendations;

5.2.5 The Quality Team is responsible for supporting all analysis activities.

5.3 **Presenting Findings and Recommendations**

5.3.1 Final reports should be presented to the Quality Improvement Committee (QIC) within 30 days of CIUT decision for concise analyses, and within 90 days of CIUT decision for comprehensive analyses (dependent on timing of QIC meetings);

5.3.2 The Analysis Lead and/or Quality Team is responsible for presenting a summary of the incident, the key findings, and the recommendations to the QIC;

5.3.3 QIC is responsible for providing feedback and approval on recommendations;

5.4 **Managing Recommendations**

5.4.1 The Analysis Lead and/or Quality Team is responsible for ensuring completion of all recommendations. This includes following up with the designated recommendation owners.

5.4.2 The Quality Team is responsible for managing the Client Safety Event Tracker.

5.5 **Sharing Learnings**

5.5.1 The Quality Team and Analysis Lead are responsible for:

i. Sharing learnings with the client/family (see *Policy 05-035-00 Client Safety Event Disclosure*);

ii. Ensuring that feedback is provided to staff who reported the incident;

iii. Sharing learnings with those impacted by the change(s);

iv. Sharing learnings and actions taken with those impacted by the change(s) and with other areas/staff where a similar event could occur.

5.5.2 Examples of platforms for sharing learnings: Morning Report, SHP meetings, Quality and Patient Safety Rounds.

6. APPENDICES:

APPENDIX A NEVER EVENTS AND URGENT TELECONFERENCE CRITERIA

APPENDIX B URGENT TELECONFERENCE TEMPLATE

APPENDIX C CRITERIA FOR SELECTING A METHOD OF ANALYSIS

7. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

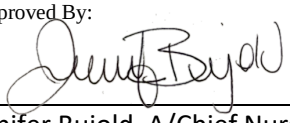
Policy 05-034-00 Client Safety Event – Incident Reporting and Immediate Management

Policy 05-035-00 Client Safety Event Disclosure Policy **REFERENCES**:

Alberta Health Services (n.d.) Immediate management checklist. Retrieved from https://www.patientsafetyinstitute.ca

Alberta Health Services (n.d.) Ongoing management checklist. Retrieved from https://www.patientsafetyinstitute.ca

St. Joseph's Healthcare Hamilton (2020, January). Safety Incident Reporting and Management – Patient and Visitor

Approved By: 	Date: July 21, 2022
Jennifer Berry, Assistant Deputy Minister – Department of Health	
Approved By: 	Date: July 12, 2022
Jenifer Bujold, A/Chief Nursing Officer	
Approved By:	Date:
Dr Francois De Wet, Territorial Chief of Staff	

Appendix A Never Events and Urgent Teleconference Criteria

Never Events for Hospital and Community Care in Nunavut

Never Event: A subset of serious adverse clinical events. These incidents are considered critical regardless of the client outcome. Never Events have known mitigation strategies that, when appropriately implemented, would prevent the occurrence of the event.

Surgical or Procedural Events
1. Surgery or other invasive procedure performed on the wrong client or wrong body part, or conducting the wrong procedure[1]
2. Unintended foreign object left in a client following surgery or other procedure[2]
3. Client death or severe harm due to the administration of the wrong inhalation or insufflation[1]
Product or Device Events
4. Client death or severe harm associated with the use or function of a device in client care in which the device is used for functions other than as intended[2]
5. Client death or severe harm arising from the use of improperly sterilized instruments of equipment provided by the healthcare facility[1]
Client Protection Events
6. Client under continuous observation leaves a health facility without the knowledge of staff[1]
7. Client death by suicide, attempted suicide, or self-harm resulting in severe harm, while being cared for in a health care facility[2] at which time the client was prescribed continuous observation[1]
Care Management Events
8. Client death or severe harm associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong client, wrong time, wrong rate, wrong preparation, or wrong route of administration)[2]
9. Client death or severe harm due to a failure to inquire whether a patient has a known allergy to medication, or due to administration of a medication where a client's allergy had been identified[1]
10. Wrong tissue, biological implant, or blood product given to a client[1]
11. Any stage 3, stage 4, or unstageable pressure ulcers acquired after admission/presentation to a healthcare facility[2]
12. Client death or severe harm of a frail client, or client with altered level of consciousness within a healthcare facility[1]
Environmental Events
13. Client death or severe harm associated with a burn incurred from any source during a client care process in a healthcare facility[2]

1. Agency for Healthcare Research and Quality (2019, September). *Never events.* https://psnet.ahrq.gov/primers/primer/3/Never-Events
2. Government of Nunavut (2017). *Pediatric and Adult – Telephone Triage Policy (07-006-00)*
3. Canadian Patient Safety Institute (2015, September). *Never events for hospital care in Canada.* http://www.patientsafetyinstitute.ca/en/toolsresources/neverevents/Pages/default.aspx

Urgent Teleconference Criteria

- All client safety incidents categorized as severity level 4 will be screened for the necessity of an urgent teleconference.
- All client safety incidents categorized as severity level 5 and 6, or identified as Never Events, will be screened for the necessity of an Urgent Teleconference; if severity level is confirmed with the information available at the time, the event will receive an urgent teleconference and further review.
- If regional staff, leadership, or the quality team deems a near miss or mild harm event to have a high risk of recurrence or high potential for harm, the event may be reviewed through the Urgent Teleconference process.

EXCLUSION CRITERION
1. Death of a palliative client where no care issues have been identified by family or staff.
Care Delivery
1. Client death or moderate to severe harm is suspected to have been associated with healthcare delivery or omission of services. Examples include: a. Issues in care raised by staff or family deemed related to the outcome; b. Breach in applicable policies/processes and accepted practices; c. Client seen within 7 days at a healthcare facility for an issue related to the outcome, or seen 3 or more time for the same complaint(s) with no clear diagnosis or improvement (refer to policy 07-035-00); d. Access to care concerns (e.g., after-hour triage, clinic closure, decreased services, unavailable staff etc.).
Surgical or Procedural Events
2. Client death intraoperatively or within 10 days of discharge from operation or procedure[1,2]
Product or Device Events
3. Client death or moderate to severe harm associated with intravascular air embolism that occurs while being cared for in a health care setting[1]
Client Protection Events
4. Minor or client of any age who is unable to make decisions, discharged to anyone other than their authorized medical travel escort [1,3]
5. Client death occurs within 10 days of receiving care or treatment for a mental health condition from a healthcare facility within the organization and partner organizations
Care Management Events
6. Client death or moderate to severe harm of maternal or neonatal client associated with labour or delivery in a low-risk pregnancy while being cared for in a healthcare facility[1]
7. Client death or moderate to severe harm resulting from the irretrievable loss of an irreplaceable biological specimen[1]
8. Client death or moderate to severe harm resulting from failure to follow-up or communicate laboratory, pathology, or radiology test results[1]
9. Client death or moderate to severe harm resulting from failure to identify and treat metabolic disturbances[3]
10. Client death or severe harm resulting from significant medical travel delay.
Environmental Events
11. Client death or moderate to severe harm resulting from the use of restraints or bedrails while being cared for in a healthcare facility[1]
Criminal Events
12. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider[1]
13. Abduction of a client of any age from a healthcare facility[1]
14. Sexual abuse/assault of a client within or on the grounds of a healthcare facility[1]
15. Client death or moderate to severe harm to a client or staff member resulting from a physical assault (e.g., battery) that occurs within or on the grounds of a healthcare facility[1]

1. Agency for Healthcare Research and Quality (2019, September). *Never events.* https://psnet.ahrq.gov/primers/primer/3/Never-Events
2. Government of Nunavut (2017). *Pediatric and Adult – Telephone Triage Policy (07-006-00)*
3. Canadian Patient Safety Institute (2015, September). *Never events for hospital care in Canada.* http://www.patientsafetyinstitute.ca/en/toolsresources/neverevents/Pages/default.aspx

Appendix B Urgent Teleconference Template

*This template is subject to minor changes; content will remain comparable to below.

Urgent Teleconference - CONFIDENTIAL

Instructions for an Urgent Teleconference

1. **Purpose**:

- Gather necessary local and senior stakeholders to understand the safety event, review steps already taken, and identify other actions that need to take place;
- Identify any additional risk and establish a mitigation plan to prevent further harm from occurring;
- Determine if staff members or health centre need any additional support *(e.g. additional staffing, critical stress management counseling)* and to identify persons responsible for action;
- Determine if additional evidence or information may need to be collected *(e.g. reports from referral sites, biomed QC information, photographs of infrastructural damage);*
- Review current disclosure provided to patient/family and identify if further disclosure is needed;
- Decide whether a further review is required, the type of review, and identify who will lead and participate in the process *(i.e. CQI/ IHS Quality, Director, etc.);*
- Identify any other action items necessary, establish who is responsible for action items identified and determine follow-up on action items identified.

The Urgent Teleconference DOES NOT:

- Replace immediate notifications;
- Replace immediate mitigation or management of an incident;
- Act as a clinical debrief;
- Act as an incident analysis process.

2. **Responsibilities**:

- Once the **Director** has been notified of a safety event, the Director must confirm the harm level reported and shall contact the Quality Team to arrange an Urgent Teleconference for:
  - Incidents resulting in severe harm or death;
  - Incidents which pose a high risk to safety (patients, staff or community).
- **The Quality Team (i.e. CQI/ IHS Quality)** is required to coordinate the teleconference. Identification of necessary participants shall be done in collaboration with the Director, Chief Nursing Officer and/or Territorial Chief of Staff.
- A brief overview of what happened with details of the event, relevant history and what has already been done in response will be provided by the **Director.** This task may be delegated to the **Immediate Manager** *(e.g. SCHP)* **or most responsible provider** *(on a case by case basis).*

3. **Timelines**:

- Calls are to be held within 24-48 hours of incident occurring *(if incident occurs on a non-business day, established notification procedures are to be followed as directed by the Client Safety - Incident Reporting and Management Policy. An Urgent Teleconference is to occur as soon as reasonably possible on the following business day.)*
- Following the decision to undertake further review, the goal is to complete the review within 90 days.

Questions or Comments?

Territorial Office: HealthCQI@gov.nu.ca **or IHS Office:** IHSQuality@gov.nu.ca

Urgent Teleconference - CONFIDENTIAL

"The information in this document has been collected for the purpose of improving the quality of health care and directly related programs and services. It is thereby conducted as a Quality Assurance Activity under the auspice of sections 13, 14, and 15 of the Nunavut Evidence Act ("the Act") as a Quality Assurance Activity."

The focus, in keeping with a just culture, is to coordinate a fair, consistent, and supportive response, and to learn from the safety event.

Date of Teleconference	Click to enter date.	**Time of Teleconference**	Click to enter.
Event Identifier (e.g., QRM)	Click to enter.	**Client Identifier (e.g., DOB)**	
Date of Safety Event	Click to enter date.		
ATTENDANCE			
☐ Facilitator (i.e., Quality)	Click to enter name.	☐ Manager/ Supervisor	Click to enter name.
☐ Chief of Staff	Click to enter name.	☐ Director	Click to enter name.
☐ Chief Nursing Officer	Click to enter name.	☐ Executive Director	Click to enter name.
☐ Most Responsible Physician	Click to enter name.	☐ Patient Relations	Click to enter name.
☐ Chief of Service	Click to enter name.	☐ Other	Click to enter name.

CASE REVIEW

1. Provide a brief overview of the events *(i.e., what happened, where and when it happened, timeline and details of the event, other relevant information)*
E.g., relevant past medical history, significant timeline leading to event, the event, resulting actions, event outcomes, contributing factors, any actions taken to prevent recurrence, other relevant safety/risk information

2. Is there any outstanding information required to understand what happened?
Choose an item.

3. With the information currently known, was the generally accepted standard of care provided?
Choose an item.

4. With the information reviewed, is anyone else immediately at risk? *(consider: are there actions required to reduce the risk of this event imminently happening again?)*
Choose an item.

5. Are there any other staff/physician(s) to be notified or referrals to be cancelled? *(e.g., sending physician/staff, pharmacy, specialists)*
Choose an item.

6. Is there evidence that needs to be preserved? *(e.g., equipment, supplies, medication, biomedical)*
Choose an item.

7. Will staff (e.g., nurses, physicians, support staff) require additional support? *(e.g., Employee Family Assistance Program (EFAP), debriefing)*
Choose an item.

8. What is ONE thing that went well during the incident?
E.g., staff communication

ASSESSMENT

9. Does this meet the definition of an incident? *(an event or circumstance which could have resulted, or did result, in unnecessary and/or unintended harm to the client. This includes near miss, no harm, and harmful events)*
Choose an item.

Urgent Teleconference - CONFIDENTIAL

ASSESSMENT CONTINUED…

10. The reported level of harm was Choose an item.. With the information provided, Choose an item., and the actual level of harm is determined to be Choose an item.

Near Miss (1): An incident that has potential for harm and is intercepted or corrected prior to reaching the patient.	Severe Harm (5): Patient outcome is symptomatic, requiring life-saving intervention or major surgical/medical intervention (e.g., prolonged hospitalization or admission to a high acuity setting such as an ICU), or shortening life expectancy or causing major permanent or long-term harm or loss of function.
No Harm (2): Patient outcome is not symptomatic or no symptoms are detected and no treatment is required.	Death (6): On balance of probabilities; death was caused or brought forward in the short term by the incident.
Mild Harm (3): Patient outcome is symptomatic, symptoms are mild, loss of function or harm is minimal or intermediate but short term, and no or minimal intervention (e.g., extra observation, investigation, review, or minor treatment) is required.	Not an Incident
Moderate Harm (4): Patient outcome is symptomatic, requiring intervention (e.g., additional operative procedure, additional therapeutic treatment, short term hospitalization for assessment and/or minor treatment in either ED or hospital unit), an increased length of stay, or causing minor permanent or long-term harm or loss of function.	Insufficient Detail: An incident for which the report carries insufficient information to evaluate the severity of harm. (Note that this is not an option within the MEDITECH QRM Module, but may be selected during the Urgent Teleconference).

11. Is this a critical incident (i.e., level 5 or 6)? ☐

12. Is this a Never Event? ☐ *If yes, immediate notification to _____ is required*

FAMILY AND DISCLOSURE

13. **Has patient/family support been offered?** Choose an item. **Comments:** Describe.

14. **Did disclosure occur?** Choose an item.

a. **If YES, by whom?** Click or tap here to enter text.; **To whom?** Choose an item.
Date of disclosure: Click here to enter a date. ; **Was it documented?** Choose an item.

15. **With the information discussed, is there anything new to disclose?** Choose an item.

a. **If YES, by whom?** Name and role.

FURTHER REVIEW AND LEARNING

16. **Is further review required?** Choose an item.

☐ *Comprehensive Incident Analysis*	☐ *Concise Incident Analysis*	☐ *Aggregate Analysis*	☐ *Educational Case Study*	☐ *Quality Improvement Project*	☐ *Professional Proficiency Review*	☐ *External Review*
Analysis facilitated by Quality Team and reviewed by QIC Typically for severe harm/ death, high context incidents, complicated/ complex incidents, incidents impacting multiple practice areas, and multi-incidents	Succinct analysis conducted by Regional Director or Unit Manager with Quality Team support Typically for no, low or moderate harm, low context incidents, simple/complicated incidents, incidents localized to one practice area	Analysis facilitated by Quality Team and reviewed by QIC For multiple incidents that are identified by a particular trend; also referred to as aggregate analysis	Group learning from an incident (e.g., M&M rounds)	Quality of care or process improvement project done at local unit or program level	Education, training, and support to staff involved *See Managing Nursing Practice and Professional Conduct Policy*	Determined by ADM-Operations, CNO, and COS after conducting a chart review or upon findings of a systems analysis

If YES, determine potential analysis team members:

Analysis Chair	Analysis Lead	Clinical Lead	Quality Resource	Frontline Staff	Other Stakeholders
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

17. **Who will be the main patient/family contact and will let them know a review is occurring?** Click or tap here to enter text.

18. **Who will conduct the patient/family interview?** Click or tap here to enter text.

19. **Who will loop back with the individual who reported the safety event? Crystal Culp**

ACTION ITEMS

20. **Action Items** *(to be sent out post-call):*

Action Item (e.g., actions to: respond to immediate incident, prevent recurrence, support staff)	MRP	Expected Completion Date

**MRPs are responsible for providing updates to the Quality Team to close the loop.
Action Items are logged in a database for tracking and data analysis purposes. Significant items will be brought to QIC.**

Appendix C Criteria for Selecting a Method of Incident Analysis

(ADAPTED FROM THE CANADIAN INCIDENT ANALYSIS FRAMEWORK)

Exceptions to the Criteria

- If the incident resulted in severe harm or death, a comprehensive analysis is required;
- If the incident meets two or more of the secondary criteria for a comprehensive analysis, a comprehensive analysis is required.

Primary Criteria	**Comprehensive**	**Concise**	**Aggregate**
Severity Level (See Appendix A: Severity Level Definitions)	Severe Harm or Death (5-6); Never Event	Reportable Circumstance to Moderate Harm (1-4)	Variable
Secondary Criteria	**Comprehensive**	**Concise**	**Aggregate**
Complexity Level (technical/social complexity, degree of predictability; simple – obtaining a blood sample via venipuncture; complicated – admitting a patient to an organization; complex – transferring a patient between organizations)	Complicated, Complex (typically, an unpredictable process and outcome with multiple interacting components)	Simple, Complicated (typically, a predictable process and outcome with few interacting components)	Simple, Complicated or Complex
Area of Impact	Team, Unit/Program, Organization, System (typically impacts or has the potential to impact multiple areas)	Team, Unit/Program, Possible Organization (typically localized to one program or department)	Team, Unit/Program, Organization, System, Sector, Industry
Context (internal pressures – historical incident data, alignment with strategic priorities, resources available; external pressures – regulatory mandates, alignment with literature/evidence)	High (e.g., significant risk identified in initial findings, evidence of recurrence, poses organizational risk)	Low (e.g., localized incident, unlikely that incident occurred previously, limited alignment with strategic priorities)	Low, Medium or High
Additional Considerations	**Comprehensive**	**Concise**	**Aggregate**
Resources Required/ Available (time, financial, human)	Moderate to Extensive (typically led by an interdisciplinary team with additional consultation; significant resources required)	Limited (typically led by one to two individuals; limited resources required)	Moderate to Extensive
Expected Timeline of Analysis	Weeks to Months (<90 days)	Hours to Days (<30 days)	Variable