Summer 2019

Did you know . . . | we read the **text fields** of **every single incident** submitted to NSIR?

National System for Incident Reporting

NSIR

Canadian Institute for Health Information
Institut canadien d'information sur la santé

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.

Inside this issue

Highlights

What we're reading: NSIR text fields

Did you know we read the text fields of every single incident submitted to NSIR? To date, that's about 7,000 pages or all 5 *Game of Thrones* books!

Why does NSIR review every incident?

NSIR is designed for sharing and learning, not for discipline or blame. We believe in a non-punitive approach to improving patient safety in health care facilities.[1]

To ensure the privacy and anonymity of facilities, patients and health care providers, the Canadian Institute for Health Information (CIHI) reviews all text fields submitted to NSIR to check for identifiers. (For more information, see our privacy impact assessment.)

When we read the text fields, we flag any text that could identify the facility, patient or health care provider, erring on the side of caution. In rare cases, we also flag acronyms, abbreviations or phrases that could lead to the identification of the specific incident.

NSIR does not edit submitted incidents. We will never change any of the data. Instead, if we see something of concern, we will flag the incident and release it back to you, along with an explanation for the flag and, in some cases, a suggested solution to the issue.

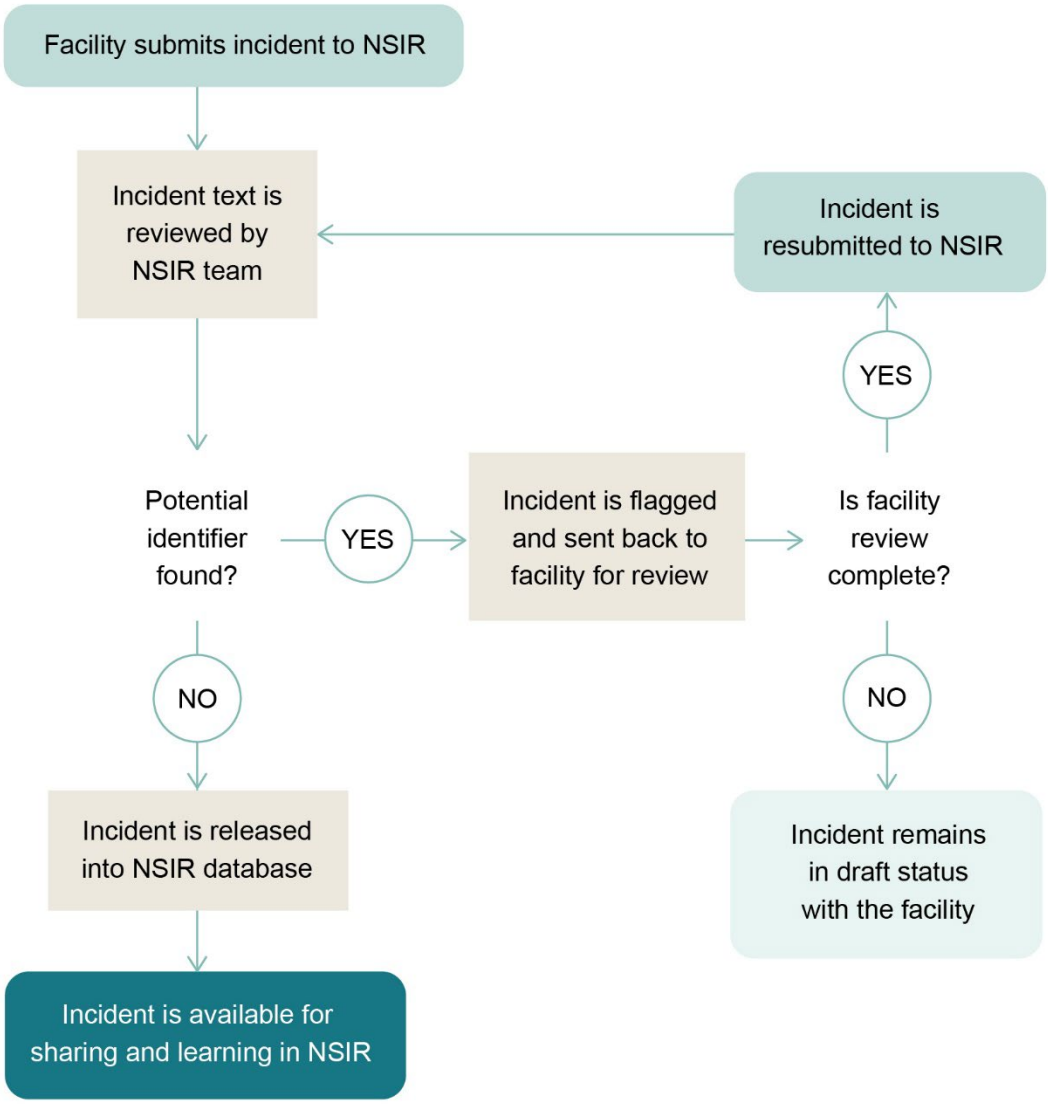
What happens after an incident is flagged?

If an incident from your facility is flagged, an email notification will be sent to NSIR users registered at your facility to inform them of the incident awaiting review. They can correct/change the incident (if necessary) and resubmit to NSIR.

How do I check for flagged incidents?

All flagged incidents are recorded in NSIR. Log in and go to the **Find** tab. Flagged incidents will appear with a status of Facility Review, which means they are awaiting review by your facility. These incidents were returned either because we flagged them or because someone at your facility asked that they be returned. Regardless, these incidents are waiting for some action or review prior to being resubmitted to NSIR. If you have any questions about your incidents, we can help! Contact us at nsir@cihi.ca.

Incident review process



Are identifiers common among incidents reported to NSIR?

No, identifiers are rarely found within the text fields of incidents submitted to NSIR. To date, 135 out of 62,471 incidents have been flagged in the identifier review process. That's 0.2% or a 1 in 5,000 chance of finding a **potential** identifier!

The majority of flagged incidents contained text that might identify the facility where the incident occurred (52%) or the provider who was involved (18%). There have been only 2 incidents that had potentially identifiable information regarding the patient (i.e., initials or first name) included in the text field.

The majority of flagged incidents (83%) were resubmitted and released to the NSIR database for sharing and learning. In fact, 44% of those were returned within 1 week of the notification.

Currently, 23 incidents remain under Facility Review, some of which are critical incidents. In an attempt to release as many of these incidents for sharing and learning, we may be reaching out to your facility for help.

If you have questions about the process, email us at nsir@cihi.ca.

Sharing and learning

Institute for Safe Medication Practices (ISMP) Canada's recent safety bulletins

Medication Safety in Long-Term Care: Measuring Quality Improvement Over 12 Years

Lack of Standardized Documentation Contributes to a Mix-Up Between Methadone and Buprenorphine-Naloxone

Palliative Care: A Multi-Incident Analysis

Critical Incident Corner

How timely is critical incident reporting to NSIR?

The vast majority of incidents (80%) are submitted to NSIR within 6 months of the date the incident was detected; only 31% are submitted within the first 30 days after detection. The quickest submission was made in 5 days and the longest was over 3 years. Ideally, critical incident reports are submitted to NSIR when the investigation is complete and recommendations can be shared. However, in some cases, new information may be discovered after the incident has been reported. If this is the case, you can always update any incident report — critical or not — by contacting the NSIR team at nsir@cihi.ca.

NSIR — Radiation Treatment (RT)

Summer 2019 NSIR-RT bulletin, from CPQR

The Canadian Partnership for Quality Radiotherapy (CPQR) publishes a quarterly bulletin. The summer 2019 issue is coming soon!

The bulletins support continuous learning from incident data through the presentation of data trends and case studies. They also provide NSIR-RT system users with information on program developments and enhancements.

Additional information

Upcoming conferences and learning

Atlantic Quality and Patient Safety Learning Exchange
October 8 and 9, 2019, St. John's, Newfoundland and Labrador
The Atlantic Health Quality and Patient Safety Collaborative, through partnership support of the Canadian Patient Safety Institute, welcomes you to attend this year's Atlantic Health Quality and Patient Safety Learning Exchange.

We look forward to welcoming innovative and engaged care providers, managers, health leaders, and academics and students from university and college settings, as well as government representatives from the 4 Atlantic provinces.

Canadian Patient Safety Week

October 28 to November 1, 2019

The Canadian Patient Safety Institute invites all Canadians — the public, providers and leaders — to become involved in making patient safety a priority.

ISMP Canada Med Safety Exchange webinar series

September 18, 2019, and November 20, 2019

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

Recent CIHI releases

Hospital stays in Canada

April 25, 2019

Key information on 2017–2018 inpatient hospitalizations, surgeries, newborns, alternate level of care and childbirth is provided in a Snapshot and data tables.

Hospital Harm Results, 2014–2015 to 2017–2018

April 18, 2019

These data tables provide updated results, aggregated at the national level (outside of Quebec), for categories and types of harm.

Nursing in Canada, 2018

June 27, 2019

These products contain information on the supply of and demographics, geographic distribution, education and employment for regulated nurses, from 2009 to 2018.

Health Workforce, 2018

June 27, 2019

These data tables contain information on the supply of and demographics, geographic distribution, education and employment for occupational therapists, physiotherapists and pharmacists, from 2009 to 2018. The indicator tables focus on health care providers who work in direct care and include information such as provider-to-population ratio, age group, country of graduation and health region of employment.

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 contact us at nsir@cihi.ca.

The NSIR eBulletin is distributed on a quarterly basis. Previous editions can be found on the NSIR web page.

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Text alternative

Incident review process

A facility submits an incident to the National System for Incident Reporting. The text is reviewed by the NSIR team. If no potential identifiers are found, the incident is released into the NSIR database and is available for sharing and learning in NSIR.

If a potential identifier is found, the incident is flagged and sent back to the facility for review. An incident remains in draft status with the facility until the facility completes a review, at which point the incident is resubmitted to NSIR. The same path begins again, with the incident text being reviewed by the NSIR team for identifiers.

Reference

1. Committee on Quality of Health Care in America; Institute of Medicine. Chapter 1: A Comprehensive Approach to Improving Patient Safety. In: Kohn LT, Corrigan JM, Donaldson MS, eds. *To Err Is Human: Building a Safer Health System*. 2000.