Submitted by

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When considering adverse events, it is important to do so in the context of quality improvement more so than in the context of risk management. The reporting and investigation of an adverse event should be the start of the improvement process and not an end in itself. The most important part should be the tracking and subsequent sharing of the interventions, and the results of the interventions, designed to prevent reoccurrence. Unfortunately, only Saskatchewan (I believe) has mandated root cause analysis on all serious events and failure mode effects analysis gets very little focus in our health system, yet root cause and failure mode hold the greatest opportunities for system improvement.

If I were to express an opinion as to the direction it would be:

1. Electronic collection of adverse events at the point of care – including identification of process failure points
2. Some method of rewarding, rather than penalizing, reporting
3. Export of de-identified events to a provincial data warehouse for research and analysis
4. Root Cause Analysis on all serious events with the causes and action plans monitored for efficacy and shared among all regions – this may require provincial support/training as RCA requires some expertise that may not be available in all locations
5. FMEA's conducted at both the local and provincial level based on analysis of events in the data warehouse.
6. Over time the integration of the DAD (discharge abstract database) combined with collecting of clinical information (diagnosis and procedure) within the adverse event would provide direction for either FMEA or process re-engineering depending on the scope of the issue.