

A tool for the concise analysis of patient safety incidents.

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<https://psnet.ahrq.gov/issue/tool-concise-analysis-patient-safety-incidents>

Once [identified](#), adverse events require investigation to understand underlying causes. Methodologies like [root cause analysis](#) are time and labor intensive, and the burden of subsequent investigation can lead to [under-reporting](#) of events. In this study, researchers tested a concise incident analysis method, drawing on multiple existing incident investigation frameworks including the [Canadian Incident Analysis Framework](#) and the [WHO High 5s program](#). Participants found the tool to be comprehensible and usable, and most reported that they would continue to use it beyond the pilot phase. These results suggest that a more streamlined method of investigating adverse events could support patient safety improvement efforts.