Professional Certificate in Clinical Risk Management

# Incident Reporting and Investigation

Adequacy Review – related terms: quality assessment, compliance check. A systematic evaluation of whether an incident report contains sufficient detail, accurate data, and meets organizational standards for further analysis.

Adverse Event – related terms: harm, unintended outcome. Any incident in healthcare that results in injury, disability, or death, or could have caused such outcomes if not for mitigating actions.

Alert Fatigue – related terms: notification overload, desensitization. A condition where frequent safety alerts diminish staff responsiveness, potentially delaying incident reporting and investigation.

Analysis Matrix – related terms: root cause matrix, fishbone diagram. A structured tool that organizes contributing factors across categories (e.G., People, process, environment) to visualize complex incident causality.

Audit Trail – related terms: record trace, documentation log. A chronological record of who accessed, modified, or reviewed an incident report, ensuring transparency and accountability.

Benchmarking – related terms: performance comparison, best practice. The process of comparing an organization's incident rates and investigation outcomes with industry standards to identify improvement opportunities.

Cause-and-Effect Diagram – related terms: fishbone diagram, Ishikawa chart. A visual representation that links a specific incident to underlying causes across multiple categories, aiding root cause identification.

Close-out Report – related terms: final summary, corrective action plan. The concluding document of an investigation that summarizes findings, actions taken, and verification of risk mitigation.

Confidentiality Clause – related terms: privacy protection, data security. A statement within reporting policies that ensures personal and patient information disclosed during an investigation is protected from unauthorized access.

Corrective Action – related terms: remediation, preventive measure. A specific step taken to eliminate identified root causes of an incident and to prevent recurrence.

Critical Incident – related terms: high-impact event, sentinel event. An event that poses immediate and severe risk to patient safety, requiring urgent reporting and investigation.

Culture of Safety – related terms: just culture, safety climate. An organizational environment that encourages open reporting, learning from errors, and non-punitive responses to incident disclosures.

Data Validation – related terms: accuracy check, verification. The process of confirming that information

entered into an incident reporting system is complete, consistent, and reliable.

De-identified Data – related terms: anonymized information, privacy shield. Patient or staff details removed from an incident report to protect confidentiality while allowing analysis.

Delay Analysis – related terms: time lag review, response interval. Examination of the time elapsed between incident occurrence, reporting, and investigation to identify bottlenecks.

Document Retention Policy – related terms: archiving rules, record lifecycle. Guidelines that define how long incident reports and investigation records must be kept before secure disposal.

Duplicate Reporting – related terms: redundant entry, double capture. Occurs when the same incident is entered into the system more than once, potentially skewing data analysis.

Electronic Incident Reporting System (EIRS) – related terms: digital platform, e-reporting. A software application that enables staff to submit, track, and analyze incident reports electronically.

Event Timeline – related terms: chronology, sequence of events. A detailed, time-ordered account of actions, decisions, and conditions surrounding an incident, essential for root cause analysis.

Failure Mode – related terms: error type, defect. The specific way in which a process or device does not perform as intended, leading to an adverse event.

Failure Mode and Effects Analysis (FMEA) – related terms: prospective risk assessment, process mapping. A systematic, proactive method for identifying potential failure modes, their causes, and the impact on patient safety before they occur.

Feedback Loop – related terms: closing the loop, communication channel. The process of informing reporters and stakeholders about investigation findings and actions taken, reinforcing reporting motivation.

Forensic Review – related terms: evidence examination, detailed audit. An in-depth investigation that examines physical, digital, or documentary evidence to reconstruct an incident precisely.

Global Harmonization – related terms: international standards, cross-border alignment. Efforts to align incident reporting definitions and processes across different countries and regulatory bodies.

Hazard Identification – related terms: risk detection, threat spotting. The initial step in incident investigation that involves recognizing potential sources of harm within a system.

Human Factors Analysis – related terms: ergonomics, cognitive load. Examination of how staff behavior, decision-making, and environmental conditions contribute to an incident.

Impact Assessment – related terms: severity rating, consequence analysis. Evaluation of the extent of harm or potential harm resulting from an incident, guiding prioritization of response.

Incident Classification – related terms: categorization, severity level. The process of assigning a reported event to a predefined category (e.G., Medication error, falls) to facilitate analysis.

Incident Command System (ICS) – related terms: emergency management, coordination structure. A standardized hierarchy used during major incidents to organize response, communication, and resource allocation.

Incident Log – related terms: record of events, tracking sheet. A chronological record that captures each step taken during the investigation, including actions, decisions, and communications.

Incident Management Policy – related terms: procedural framework, governance. The formal document that outlines responsibilities, reporting pathways, and timelines for handling incidents.

Incident Severity Scale – related terms: risk matrix, grading system. A tool that assigns numeric or descriptive levels (e.G., Minor, moderate, severe) to quantify the seriousness of an incident.

Incident Trend Analysis – related terms: pattern detection, longitudinal review. Statistical examination of incident data over time to identify recurring problems or emerging risks.

Information Governance – related terms: data stewardship, compliance. The set of policies and procedures that ensure incident data is managed responsibly, securely, and in accordance with regulations.

Informed Consent Breach – related terms: ethical violation, patient rights. An incident where a patient's consent was not properly obtained or documented, potentially leading to legal and safety implications.

Instrument Calibration Error – related terms: equipment drift, measurement inaccuracy. A specific type of failure where a medical device provides inaccurate readings due to improper calibration, often reported as an incident.

Job Hazard Analysis (JHA) – related terms: task risk assessment, workflow safety. A systematic approach to evaluating each step of a clinical task to identify potential hazards before they lead to incidents.

Key Performance Indicator (KPI) – related terms: metric, performance measure. Quantitative measure used to evaluate the effectiveness of incident reporting and investigation processes (e.G., Reporting rate, closure time).

Learning Health System – related terms: continuous improvement, data-driven care. A framework where incident data feeds back into practice changes, creating an ongoing cycle of learning and safety enhancement.

Loss Prevention – related terms: risk mitigation, asset protection. Strategies aimed at reducing the frequency and impact of incidents that could cause financial or reputational loss.

Medical Device Reporting (MDR) – related terms: device adverse event, FDA reporting. Mandatory reporting of incidents involving medical devices that result in injury or malfunction, often integrated into broader incident systems.

Mitigation Strategy – related terms: risk reduction plan, control measure. A set of actions designed to lessen the likelihood or severity of a recurrence after an incident's root causes are identified.

Near Miss – related terms: close call, precursor event. An event that could have caused harm but did not, either by chance or timely intervention; valuable for proactive safety learning.

Non-Punitive Reporting – related terms: just culture, safety encouragement. An approach that protects reporters from disciplinary action, fostering openness and higher reporting rates.

Observation Study – related terms: field audit, direct monitoring. A method where investigators watch clinical processes in real time to identify latent conditions that may lead to incidents.

Open Disclosure – related terms: transparent communication, apology protocol. The practice of informing patients and families about an incident, its impact, and steps taken to prevent recurrence.

Organizational Learning – related terms: knowledge capture, systemic improvement. The process by which insights from incident investigations are assimilated into policies, training, and system redesign.

Outcome Measure – related terms: clinical indicator, result metric. A specific variable used to assess the effect of an intervention or corrective action implemented after an incident.

Patient Safety Event (PSE) – related terms: adverse event, safety incident. Any occurrence that compromises the safety of a patient, encompassing errors, near misses, and system failures.

Performance Gap – related terms: variance, deviation. The difference between expected safe practice and actual performance observed during an incident investigation.

Pharmacovigilance – related terms: drug safety monitoring, adverse drug reaction. The systematic collection, assessment, and prevention of medication-related incidents.

Process Mapping – related terms: workflow diagram, flowchart. Visual representation of each step in a clinical process, used to pinpoint where breakdowns may have occurred.

Probability of Harm – related terms: risk likelihood, exposure assessment. An estimation of how likely it is that a particular failure mode will result in patient injury.

Quality Improvement (QI) Cycle – related terms: PDSA, continuous improvement. A structured approach (Plan-Do-Study-Act) that uses incident data to test and implement changes.

Root Cause Analysis (RCA) – related terms: deep dive, causation study. A systematic method for identifying the fundamental underlying reasons an incident occurred, beyond immediate causes.

Safety Culture Survey – related terms: staff perception assessment, climate index. An instrument used to gauge employee attitudes toward safety, reporting, and accountability.

Safety Net – related terms: backup process, fail-safe. Redundant checks or procedures designed to catch errors before they result in harm.

Severity Index – related terms: harm grading, impact score. A numeric or categorical value assigned to an incident reflecting the level of patient injury or potential injury.

Significant Event Audit (SEA) – related terms: clinical review, peer assessment. A formal review of selected incidents to extract learning and share best practices across departments.

Simulation Review – related terms: virtual scenario, mock drill. Use of simulated environments to replicate incidents for analysis without exposing real patients to risk.

Stakeholder Engagement – related terms: participatory approach, collaborative review. Involving clinicians, patients, and administrators in the investigation process to ensure diverse perspectives.

Standard Operating Procedure (SOP) – related terms: process guideline, work instruction. Documented step-by-step instructions that define how routine tasks should be performed to minimize error.

Systemic Failure – related terms: organizational weakness, latent error. A breakdown in the underlying structures, policies, or culture that allows an incident to occur.

Temporal Analysis – related terms: time-based review, chronology assessment. Examination of the timing of events (e.G., Shift changes) to identify temporal risk factors.

Trend Dashboard – related terms: visual analytics, real-time monitoring. An interactive display that presents key incident metrics, allowing managers to spot emerging issues quickly.

Trigger Event – related terms: catalyst, initiating incident. The specific occurrence that sets off a chain of events leading to a reported safety incident.

Validation Study – related terms: instrument testing, reliability check. Research conducted to confirm that a reporting tool accurately captures the intended data.

Verification of Action – related terms: effectiveness check, follow-up audit. The process of confirming that corrective actions implemented after an incident are functioning as intended.

Voluntary Reporting – related terms: self-initiated entry, optional disclosure. When staff choose to submit an incident report without external prompting, reflecting a proactive safety mindset.

Workflow Bottleneck – related terms: process choke point, delay point. A stage in a clinical process where tasks accumulate, increasing the risk of errors and incidents.