

CANADIAN INCIDENT ANALYSIS FRAMEWORK

Sample Analysis Team Charter

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D. SAMPLE ANALYSIS TEAM CHARTER

Date From:

Subj: Analysis Team Charter Memo To:

1. This memo confirms that an Analysis Team will be convened to determine the contributing factors for the patient safety incident analysis briefly described below.

Date Incident Occurred / / Date Organization was Aware of Incident / /

The analysis method is (check one): Comprehensive Concise Multi-Incident

1. As part of the process, the team will be responsible for developing a final report and recommendations based on their expert analysis. All analyses are quality assurance, focused processes, and the team’s products (e.g. interviews, preliminary and final reports, etc.) are considered confidential, privileged and protected under XYZ Act.

*Note: If in the course of conducting the analysis it appears that the patient safety incident(s) under consideration may have been related to an intentional unsafe act or acts, the appropriate organizational representative will be contacted to determine if an administrative review, or other type of review process, should occur. See Section 3.2*

*for additional information.*

1. List of disciplines and/or services anticipated to be involved in this analysis:
2. List of potential internal (e.g. facility) and external experts or consultants:
3. Resources available to the team (e.g. room number, flip charts, laptop computer, etc.)
4. The team’s final report is due on: / /

(Adapted from the Veterans Affairs National Center for Patient Safety, in the Canadian Root Cause Analysis Framework)7

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