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Title **Methodology for Prevention and Management of Safety Incidents in Critical Care**

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Aim

To systematize the risk management tools (described in the literature) for continuous improvement processes of care in health facilities so as to contribute to a culture of safety in care.

Conclusions and result

Clinical risk management and the systematization of safety of care are relatively new areas in the planning of health systems. The transfer of these techniques and technologies from the industrial sector is not yet reflected in research and results on methodological quality. Two different methodologies for retrospective or prospective analyses of critical events have been selected and recommended. Good quality evidence is not available to inform management practices.

Recommendations

The London Protocol is recommended for retrospective analysis of incidents. It contains elements of root cause analysis, but focuses on the organization as a whole. Incidents are viewed as more systemic and not as having a unique cause. Modal Analysis and Effects (FMEA) is recommended for prospective analysis. This technique places the emphasis on the prevention of errors that may occur, hypothetically, in the process of patient care.

Methods

The systematic search aimed to identify health technology assessment reports and systematic literature reviews that describe and evaluate implementation of the risk management techniques used in industry, and their subsequent application in the health field. Databases searched for 2007 through 2009 were: DARE, Cochrane Library, Tripdatabase, and LILACS.

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