

SIGNIFICANT EVENT ANALYSIS – PRIMARY CARE

A. INCIDENT MANAGEMENT CONTINUUM

- 1) **Before** the Incident – leadership, safe & just culture, plan resources
- 2) **Immediate** Response – support patients, providers; report; secure; disclose; reduce risk
- 3) **Prepare** for Analysis – preliminary investigation, identify team, plan interviews & meetings
- 4) **Analysis** Process
- 5) **Follow Through** – implement recommendations, monitor & assess effectiveness
- 6) **Close** the Loop – share what was learned (spread)

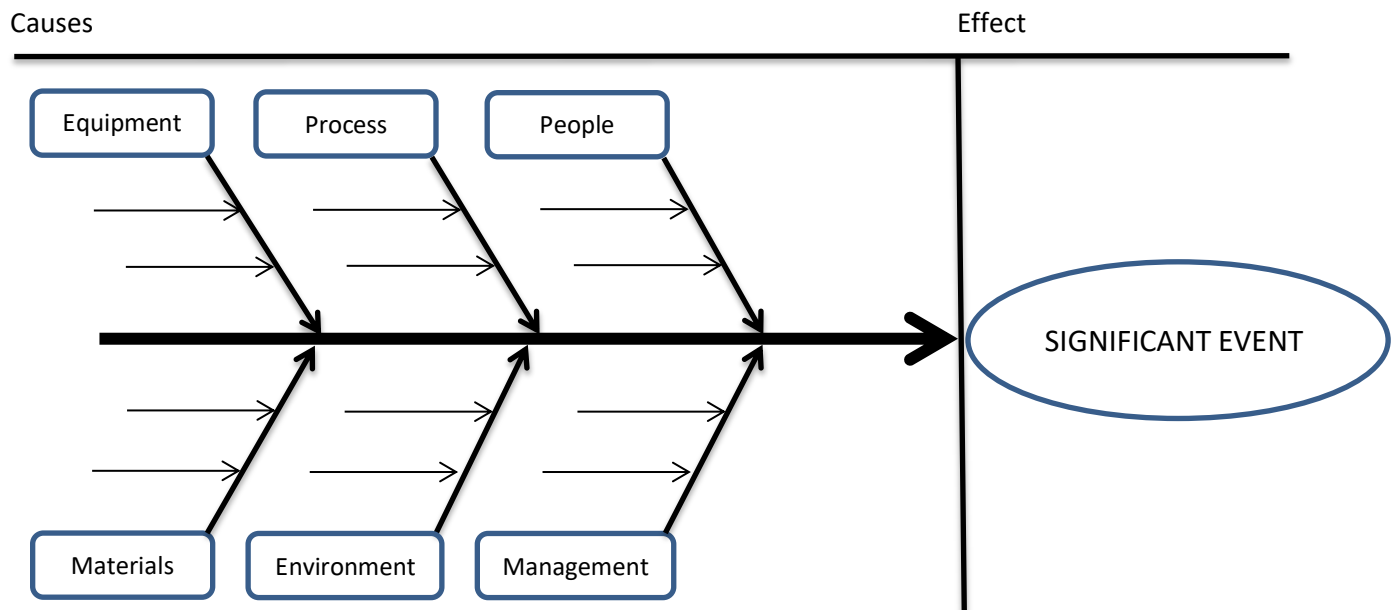
B. ANALYSIS

1. **What Happened**
2. **How & Why did it Happen**
3. **What can be Done to Reduce Risk of Recurrence**, i.e. Make Care Safer

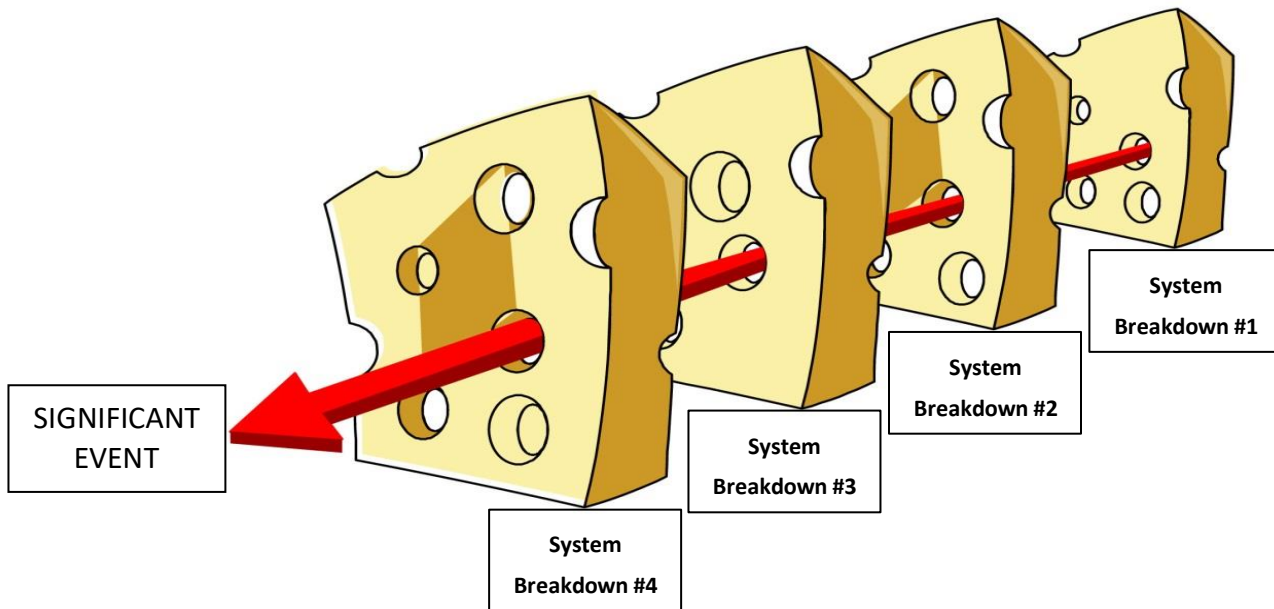
C. TOOLS FOR ANALYSIS

- i. Fishbone Diagram of Incident (Ishikawa Diagram)
- ii. Reason's Swiss Cheese Model

i. Fishbone Diagram



ii. Reason's Swiss Cheese Model



D. SUMMARIZE & PRIORITIZE RECOMMENDED ACTIONS

For each Recommendation, identify

- i) Risk (of incident happening again)
- ii) Priority (of opportunity to improve)
- iii) Predictors of Success (for changes to system)
- iv) System Levels Targeted
- v) Implementation of improvement opportunity (what next steps are required)

E. OTHER EXPECTATIONS

To promote a "Safe" Culture:

- a. Review the Analysis with all members involved before its release.
- b. Ensure the Analysis stays at the SYSTEM LEVEL. Avoid Human Factor analysis.
- c. Ask each person involved in the Analysis to sign a CONFIDENTIALITY AGREEMENT.
- d. Maintain the anonymity of individuals involved in the Analysis of What Happened.

F. ADAPTED FROM:

1. **Canadian Incident Analysis Framework**, Canadian Patient Safety Institute (CPSI), Institute for Safe Medication Practices Canada, Saskatchewan Health, Patients for Patient Safety Canada, Edmonton, AB, 2012
2. **Patient Safety and Incident Management Toolkit**, CPSI, 2015, <http://www.patientsafetyinstitute.ca/english/toolsresources/patientsafetyincidentmanagementtoolkit/Pages/default.aspx>
3. **Patient Safety & Clinical Skills: Significant Event Analysis**, NHS Education for Scotland, <https://learn.nes.nhs.scot/Resource/View/514> and http://www.nes.scot.nhs.uk/media/346578/sea - full_guide - 2011.pdf