Safety Event Investigation Tool
Identify Opportunities for Improvement

Purpose: To be used after identification of a *defect* in the care process (anything you do not want to happen again)

Instructions:
- Try to investigate as soon as possible to understand why certain decisions were made.
- Have a multidisciplinary group of people (e.g., nurse, physician, administrator, pharmacist) present for discussion. Encourage participants to use blameless feedback and observations to support improvement.
- Discussion can be brief: 10-15 minutes. Appoint a person to document debrief below for learning purposes.
- Share key elements of learning within the department to promote improvement.

Type of Safety Event:
☐ Hospital-Acquired Infection
☐ Significant Adverse Drug Event
☐ Risk event, claim
☐ Operational defect: _____
☐ Other safety defect: _____

1. What happened?

2. Why did it happen? Where did the system break-down to allow this event to occur?
(Consider system factors categories attached.)

3. What will we do to reduce the probability of it happening again?

Action: _____

Point Person: _____

Follow up Date: _____

Action: _____

Point Person: _____

Follow up Date: _____

4. How will we know if these changes have worked?

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5. How will we communicate the lessons learned from this investigation and any resulting changes in processes?

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Examples of System Factors That May Contribute to a Safety Defect

Below is a list of system factors with examples to help clarify the meaning of the factor.
Source: Johns Hopkins Quality and Safety Research Group

Patient Factors
• Was the patient acutely ill or agitated? *(elderly patient in renal failure, secondary to congestive heart failure)* • Was there a language barrier? (*patient did not speak English)* • Were there personal or social issues? *(patient declined therapy)*
Task Factors
• Was there a protocol available to guide therapy? *(protocol for mixingmedication concentrations is posted above medication bin)* • Were test results available to help make care decision? (*stat blood glucose results were sent in 20 minutes)* • Were test results accurate? *(four diagnostic tests done; only MRI results needed quickly – results faxed)*
Caregiver Factors
• Was the caregiver fatigued? *(tired at the end of a double shift; nurse forgot to take blood pressure)* • Did the caregiver's outlook/perception of own professional role impact on this event? *(doctor followed up to make sure cardiac consult was done expeditiously)* • Was the physical or mental health of the caregiver a factor*? (caregiver having personal issues and missed hearing a verbal order)*
Team Factors
• Was verbal or written communication during hand offs clear, accurate, clinically relevant and goal directed? *(oncoming care team was debriefed by outgoing staff regarding patient's condition)* • Was verbal or written communication during care clear, accurate, clinically relevant and goal directed? *(staff was comfortable expressing his/her concern regarding the plan of action)* • Was verbal or written communication during crisis clear, accurate, clinically relevant and goal directed? *(team leader quickly explained and directed his/her team regarding the plan of action)* • Was there a cohesive team structure with an identified and communicative leader? *(attending physician gave clear instructions to the team)*
Training and Education Factors
• Was caregiver knowledgeable, skilled & competent? *(nurse knew dose ordered was not standard for that medication)* • Did caregiver follow the established protocol *(caregiver pulled protocol to ensure steps were followed)* • Did the caregiver seek supervision or help? *(new nurse asked preceptor to help her/him mix medication concentration)*
Information Technology/CPOE Factors
• Did the computer/software program generate an error*? (Heparin was chosen but Digoxin printed on the order sheet)* • Did the computer/software malfunction? *(computer shut down in the middle* of caregiver's order entry) • Did the user check what he/she entered to make sure it was correct*? (caregiver initially chose .25 mg but caught his/her error and changed it to .025 mg)*
Local Environment

- Was there adequate equipment available and was the equipment working properly? *(there were 2 extra ventilators in stock and recently serviced by clinical engineering)*
- Was there adequate operational (administrative and managerial) support? *(unit clerk out sick, but extra clerk sent to cover from another unit)*
- Was the physical environment conducive to enhancing patient care? *(all beds were visible from the nurse's station)*
- Was there enough staff on the unit to care for patient volume? *(nurse ration was 1:1)*
- Was there a good mix of skilled with new staff? *(there was a nurse orientee shadowing a senior nurse and an extra nurse on to cover senior nurse's responsibilities)*
- Did workload impact the provision of good care? *(nurse caring for 3 patients because nurse went home sick)*

Institutional Environment

- Were adequate financial resources available? *(unit requested experienced patient transport team for critically ill patients and one was made available the next day)*
- Were laboratory technicians adequately in-serviced/educated? *(lab tech was fully aware of complications related to thallium injection)*
- Was there adequate staffing in the laboratory to run results? *(there were 3 dedicated laboratory technicians to run stat results)*
- Were pharmacists adequately in-service educated? *(pharmacists knew and followed the protocol for stat medication orders)*
- Did pharmacy have a good infrastructure (policy, procedures)? *(it was standard policy to have a second pharmacist do an independent check before medications were dispensed to the until)*
- Was there adequate pharmacy staffing? *(there was a pharmacist dedicated to the ICU)*
- Does hospital administration work with the units regarding what and how to support their needs? *(guidelines established to hold new ICU admissions in the ER when beds not available in the ICU*)