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

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<th>Causes</th>
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   SIGNIFICANT EVENT
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:**