# Safety Event Investigation Tool

**Goal:** To identify opportunities for improvement

**Purpose:** To be used after a patient safety event (anything you do not want to happen again)

**Instructions:**

- Investigate as soon as possible while people still remember details
- Have a multidisciplinary group of people (e.g., technician, veterinarian, administrator, etc.) present for discussion
- Encourage participants to use blameless feedback and observations to support improvement
- Discussion can be brief: 20-25 minutes. Appoint a person to document debrief discussion for learning purposes (see below)
- Include medical, anesthesia, treatment record review
- Formulate a clear action plan and define a timeline
- Share key elements of learning within the larger team to promote improvement

**Type of Safety Event:**

- ❑ Near Miss
- ❑ Patient Safety Event – minor injury
- ❑ Patient Safety Event – major injury, including death
- ❑ Adverse Reaction

**1. What happened?**

**2. Why did it happen? Do we have a system / guideline in place for this situation?**
(consider system factors categories)

**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 worked?**

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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.

| **Patient Factors** |
| --- |
| Was this patient in a high-risk category?<br>Was the patient history clear and complete?<br>Was the patient anxious or stressed? |
| **Task / Procedure Factors** |
| Was there a guideline available to guide therapy or the procedure?<br>Were accurate test results available to help make decisions?<br>Was the right support available to complete the procedure?<br>Was the area close to the procedure quiet to allow focus on the task or procedure? |
| **People Factors** |
| Was fatigue a factor?<br>Did team members have enough support to complete the task?<br>Did team members follow established guidelines? |
| **Team Communication Factors** |
| Was verbal or written communication during hand offs clear, accurate, clinically relevant?<br>Was verbal or written communication during an acute crisis clear, accurate, clinically relevant and goal-directed?<br>Was there a cohesive team structure with an identified and communicative leader? |
| **Training and Education Factors** |
| Were team members trained, skilled and comfortable with the task?<br>Was additional help and support available? Was it used?<br>Was there a good mix of skilled and new staff? |
| **Leadership** |
| Are team members encouraged to ask questions and ask for help?<br>Is patient safety a priority and supported by the leadership team?<br>Do team members work collaboratively with the attending veterinarian on the care of the patient? |
| **Environment / Equipment** |
| Was there adequate equipment available and was the equipment working properly?<br>Was there adequate operational (administrative and managerial) support?<br>Was the physical environment conducive to enhancing patient care?<br>Was there enough staff to care for patient volume? |

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