Basic Event Analysis for Managers:

- Make sure the event is reported in the system: ers.wusm.wustl.edu
- > Thank the reporter every time. It takes courage and you can support this.
- ➤ If it involves harm and they were involved, ask how they are. **Taking care of those** involved is vital. Remind them of the *substitution test*.
- ➤ How did it happen? ("I made an error" or "I was busy", etc. doesn't help) Many people stop here. Human error is our baseline--our job is to expect that and create a safety net.
- ➤ Yes, but how did the error happen? (You may have to ask several times.) You are looking for steps that indicate broken process—how the process failed—or human factors like interruptions, etc.
- Can you walk me through your process? (use chart or other records). "Help me understand your process and why you do it that way"? Find out if they have a professional routine they always use.
- What didn't go according to plan? Why?
- What ideas do you have for moving forward?
 When something bad or upsetting happens, they have been playing it over and over in their minds. Don't waste this. This is precious material and may be the clue to what would save others from the same mistake, and keep patients safe.

> Ask yourself:

- Do I have all the facts? Who else do I need to speak to?
- Put follow up, including interviews in the system. This will help in the analysis
- Serious events should always be called to Risk Management before investigation
- Could it happen to someone else? (Substitution Test)—this is the clue to one of these:
 - 1) everyone does it like this;
 - 2) no procedure exists; or procedure is not practical; or
 - 3) practice has crept far from the agreed-upon standard (practice creep is a leadership issue which we can work on)
- Remember: "What happened" is more important than "Who did it"? unless the "who" keeps repeating. (Use Just Culture Algorithm to determine actions. We don't blame people for system flaws, but hold them accountable for a personal profession routine.)