3A(3)

GUIDANCE NOTES ON UNDERTAKING SIGNIFICANT EVENT ANALYSIS & DRAFTING A REPORT

Introduction

Significant event analysis (SEA) is strongly encouraged in primary care as a structured way of learning, improving patient care and minimising risk. It is a form of audit but unlike the method of (criterion-based) audit previously explained, it deals with reviewing single cases or events rather than groups of patients with specific conditions or high-volume workload issues. That is not to say, however, that a single event cannot act as a trigger for a conventional audit to be undertaken in these areas.

SEA is mainly a team-based activity where the emphasis is on learning from an event and changing practice in order to minimise the chances of it recurring in future. It is a non-threatening technique that encompasses a 'no blame' approach, where we look at what (systems) is wrong and **not** who (individuals) is wrong. Failure to adopt this philosophy in the practice will discourage team members from highlighting and discussing significant events and lead to missed opportunities to address issues requiring change.

What is a significant event?

"Any event thought by anyone in the team to be significant in the care of patients or the conduct of the practice". (Pringle *et al*, 1995)

The definition of a significant event outlined here is a very broad based one. It should be noted that significant events do not have to be 'critical' or 'adverse', but can also 'celebrate' the confirmation of good practice. In reality, however, most significant events, whether clinical or administrative, can be broadly categorised as adverse occurrences, near misses or errors i.e. they tend to deal with 'negative' incidents.

Selection of significant event topics

The selection of significant event topics is very important as the wrong selection can lead to conflict, bad feeling and low morale – so care must be taken when considering events for discussion.

SEA topics that should not be used for discussion include those where individuals or groups of staff have a hidden agenda. Other topics that are inappropriate for SEA include those where individual poor performance (e.g. lateness, slackness, work difficulties) has been identified. SEA is not the forum for this, nor is it the forum for personal matters (e.g. personal hygiene, dress code, attitude), confidential matters (staff health) or contractual matters (pay, working-hours etc). The practice should have appropriate mechanisms in place to deal with these issues.

What is a significant event ANALYSIS?

Simply acknowledging and discussing a significant event amongst colleagues after it happens is not enough – it is likely to recur if that is all that is done. The SEA technique allows for a structured analysis to be performed so that a clear picture of what happened and why is established, insight into the event is demonstrated, change is introduced (if appropriate) and lessons are learned. The end result being that the chance of the event happening again is hopefully minimised.

Drafting a SEA Report

When undertaking and documenting a significant event analysis we should ask ourselves four questions (see forms D and E):

1. What happened?

2. Why did it happen?

3. What has been learned?

4. What has been changed?

What Happened?

In this section of the report all of the facts relating to the identified significant event should be described so that those reading the report (e.g. your Appraiser or Practice Accreditation Assessor) can get a clear picture of the details of the event - including dates and times. The significant event being described should be evaluated because it deals with a quality of care or patient safety issue, or has personal impact on staff or an effect on the practice as a whole.

Why did it happen?

In this section clear reasons should be provided as to why the event occurred based on the evidence collated from those directly and indirectly involved. This allows the team to identify and focus on the issues that may require to be addressed.

What have you learned?

An explanation should be given of any learning you and the team have identified. For example, these may be related to learning issues concerned with therapeutics, disease management or administrative procedures. However, it could also reflect a learning experience in dealing with patients, colleagues, staff, or other organisations.

What have you changed?

With most significant events, a change in some aspect of care is required to improve the quality of care and/or minimise the risk that a similar event will occur. If this is the case then a description of the change actually implemented should be given rather than a "wish list" of thoughts, which may minimise risk but have not yet been carried out.

On occasions it may not be possible to implement change either because the likelihood of the event happening again is so rare or because change is outwith the control of the individual or the organisation. If this is the case then the reasons behind this should be clearly documented.

Finally, significant events need not necessarily be adverse events or near misses, but can reflect high quality care. In this case the reason for not changing any aspect of care can be easily documented, as it is obviously not required.

Attachments

Significant Event Analysis Proforma (Form D)

Sample SEA Report (Form E)

Further Reading

SIGNIFICANT EVENT ANALYSIS:

Bowie P, McKay J, Lough M (In Press). Peer assessment of significant event analyses: being a trainer confers an advantage. *Education for Primary Care.*

McKay J, Bowie P, Lough M (2003). Evaluating significant event analyses: implementing change is a measure of success. *Education for Primary Care,* **14**(1): 34-38.

Pringle, M., & Bradley, C. (1994). Significant event auditing: a users' guide. Audit Trends, **2**, 70-73.

Pringle M., Bradley C, Carmichael C, Wallis H, & Moore, A (1995). Significant event auditing: A study of the feasibility and potential of case-based auditing in primary medical care. Royal College of General Practitioners, London.

Sweeney G, Westcott R, Stead J (2000). The benefits of significant event audit in primary care: a case study. Journal of Clinical Governance, 8:128-134.

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