NHS Education for Scotland

Driving Improvements in Healthcare: Implementation Evidence

6 Learning Brief 6: Enhancing the Effectiveness of Significant Event Analysis

Introduction

- It is currently estimated that levels of harm in hospital range from 3-25% (1).
- For primary care, it is currently thought that approximately 1-2% of consultations may include adverse events (2).
- In both these settings, many of these incidents are thought to be preventable.
- Improving patient safety is one of the key priorities of the NHS, and a range of developments and policy initiatives have been implemented to reduce unintentional harm and improve patient experiences (3).

Significant Event Analysis

- A broad definition of a significant event is "any event that any member of the team considers to be significant in terms of care of the patient and the conduct of the practice" (3).
- Whilst the term 'significant event' may have a negative connotation, it may also refer to a positive scenario.
  - *A 33 year old woman developed an allergic reaction to penicillin prescribed for a sore throat. Her records were not available on the day she consulted. They showed that, at her new patient check 1 year earlier, the practice nurse had recorded that she was possibly allergic to penicillin.* (3)
  - *A GP team demonstrated exemplary care in successfully resuscitating a man who collapsed in the surgery waiting room.* (3)
- Learning from significant events and any follow up actions are shared during structured Significant Event Analysis (SEA) team meetings.
- The focus is on enhancing safety, managing risk, and facilitating the reporting of safety incidents (4).

The SEA Technique

1. Identify and prioritise a significant event for analysis.
2. Collate as much factual information on the event as possible.
3. Convene a meeting to discuss and analyse the significant event.
4. Undertake a structured analysis of the significant event.
5. Monitor any changes agreed and implemented.
6. A written record (report) of every SEA is undertaken.
7. The findings from the report should be shared and reviewed with GP team members.

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Summary

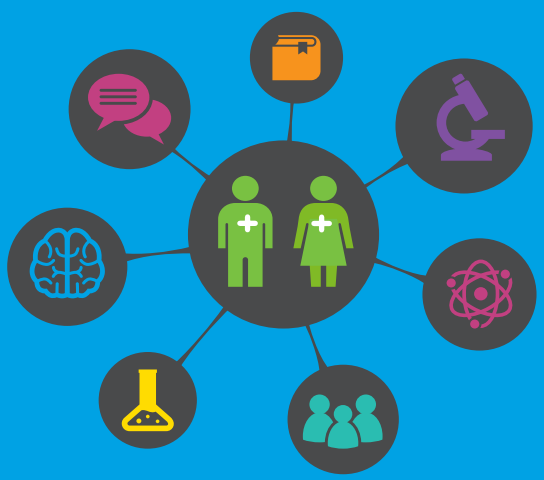
- The SEA technique is a reflective educational intervention that aims to support patient safety.
- It presents an opportunity for teams to directly contribute to improvements, thus valuing and engaging all staff.
- In addition, these discussions encourage inter-professional dialogue, team-working and prompt decision making for positive change and improvement.
- Whilst the SEA technique was developed and tested with primary care teams, the approach is also suitable within any health and social care setting.
- Overall, the process allows for learning and reflection at individual, team and organisational levels; further contributing to ongoing service quality and clinical safety improvement.

References

1. The Health Foundation. Evidence scan: Levels of harm. London: The Health Foundation; 2011. Available from: http://www.health.org.uk/sites/default/files/LevelsOfHarm_0.pdf
2. The Health Foundation. Levels of harm in primary care. London: The Health Foundation; 2011. Available from: http://www.health.org.uk/publication/levels-harm-primary-care
3. Bowie P. Learning from significant events. Pract Nurse. 2010;39(12):11–5.
4. McKay J, Bradley N, Lough M, Bowie P. A review of significant events analysed in general practice: implications for the quality and safety of patient care. BMC Fam Pract. 2009;10:61.

Use the Significant Event Analysis Report Template

- Driving Improvements in Healthcare: Implementation Evidence. Learning Briefing 6: Enhancing the Effectiveness of Significant Event Analysis. NHS Education for Scotland, 2017.
- http://patientsafety.nes.nhs.scot
- https://learn.nes.nhs.scot/Resource/View/973



NHS Education for Scotland is a national health board responsible for education, training and workforce development for those who work in NHS Scotland. We undertake a range of patient safety educational research to support the delivery of safe, effective and person-centred care.

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