Step 1
Diagnose
Significant Event Analysis (SEA)

Royal College of General Practitioners

Significant Event Audit (SEA) - also called Significant Event Review or Analysis - is an increasingly routine part of general practice. It is a technique to reflect on and learn from individual cases to improve quality of care overall. An SEA is usually undertaken to prevent recurrence of an adverse event. Positive events are often "near-misses" and an SEA can serve to celebrate good practice while alerting colleagues to potential pitfalls.

Significant event audits can form part of an individual's and practice based learning and quality improvement.

How to

These are usually done when any event is thought to be significant in patient care or in the running of the practice. Whether clinical, administrative or organisational, the SEA process enables the following questions to be answered:

- What happened and why?
- What was the impact on those involved (patient, carer, family, GP, practice)?
- How could things have been different?
- What can we learn from what happened?
- What needs to change?

SEA team discussions is an opportunity for the team to:

- Discuss each stage in detail.
- Use a no blame approach
- Identify any learning needs.
- Identify actions to be taken and changes to be made and agree how these will be processed.
- Any actions or learning undertaken can be re-assessed at a future date.

In 2015/2016 the RCGP undertook a pilot project in Early Diagnosis of Cancer and Quality Improvement using Significant Event Analysis. Further information on using SEA in this field can be found on the RCGP website.

Enhanced SEA

Enhanced significant event analysis is a further improvement to the existing SEA structure. A 'human factors' approach was taken in an NHS Education for Scotland (NES) pilot funded by the Health Foundation Shine programme. It considers contributory factors to an event and their interactions under headings:

- People factors
- Activity factors
- Environment factors.

Human factors addresses problems by modifying the design of the system to better aid people: to understand and limit conditions in the system that predispose an individual to make an error and to reduce the risk of errors leading to harm.

There are three phases:

1. Addressing the personal impact of an event.
   This is usually done on your own.
   - How did the event make you feel?
   - Address these feelings realising that an event is rarely related to the actions of a single person.

2. Applying a human factors framework.
   This is usually done with all involved and consider the contributing factors under the following:
   - People: Individual, Patients, Team, Other
   - Activity: Complexity of process or work, Guidelines, policies and procedures, Procedural/task design, Equipment
   - Environment: Work setting, Organisational, Communications, Education and training, Societal/regulatory and cultural influences.

3. Define the action plan, including learning.
   A report template can be used to circulate to those who were not in the discussion and can be used as evidence in appraisal. The template can have the headings described below:
   - About the significant event
     - What happened
     - What impact
   - Contributory human and system factors
     - Describe the factors
     - Why the factors contributed
     - How did they combine
   - Lessons learned
   - Action plan
     - Plan for improvement
     - How minimise chances of happening again
     - Who is responsible for actions
     - Monitoring of actions

Guide tools, a report format, a learning module and further information are available on the NHS Scotland Quality Improvement Hub website.