MDU

9 Medico-legal guide to Significant event analysis

Significant event analysis is a way of formally analysing incidents that may have implications for patient care. Learning from what went wrong or right should help improve your practice.

When something goes wrong

It is likely that you will be involved in an adverse incident at some point in your career. While you should focus on minimising error, the way you respond when something goes wrong is of paramount importance.

Several regulatory and healthcare bodies highlight the need to report and learn from errors. The GMC expects you to be open and honest if things go wrong[1] and to co-operate with any formal inquiry into the treatment of a patient[2]. Learning from incidents is a key part of the NHS complaints procedure. Assessing and monitoring the quality of service provision is an essential standard for Care Quality Commission (CQC) compliance[3] and for GPs, analysis of significant events is a requirement under the Quality and Outcomes Framework (QOF)[4].

In order to revalidate, you will be expected to provide evidence at your appraisal that you have participated in significant event analysis.

We advise that you should incorporate reflection on adverse events into your professional practice and this guide provides advice on the processes to follow when something goes wrong.

Identify the incident

The first step in the process is to identify the incident. Examples of incidents that you might report include:

- unexpected deaths
- delayed or missed diagnoses
- medication errors
- communication failures.

You should report any circumstance where you believe something has gone wrong, as lessons can be learned from a wide range of situations. It is important that you highlight any problem or potential problem so that future change can be considered. Your organisation may have specific reporting guidelines and these should be followed.

Report the incident

There should be an established method for reporting incidents, such as a simple paper or electronic form. Reports should be submitted to a nominated individual who is responsible for overseeing the process. In general practice, this might be, for example, the practice clinical governance lead. In hospitals this is likely to be the clinical governance/risk management department.

It is important that staff are trained so they know what is expected of them. You should develop a culture where staff feel comfortable about reporting incidents. They need reassurance that the system is not intended as a disciplinary procedure.

They will need to be encouraged to report incidents, knowing that they will not be inappropriately or unfairly blamed, either for the incident itself or for reporting it. This can be demonstrated over time by applying the policy consistently and confidence should build as a result.

Create a system that staff will find easy to use. The person who was involved in, discovered or witnessed the incident should complete the report as soon as possible after the event. The report should be factual and avoid expression of personal opinion, and should be passed quickly to the nominated individual.

Act on the incident

The nominated individual should review the data and check that any urgent remedial action is in hand. Many organisations will have a system of classifying adverse incidents and this may then guide the level of investigation and analysis required.

Often organisations will dedicate regular time slots for incident reviews. The nominated person should make a judgment whether the adverse incident should form part of the agenda, and whether it can wait until the next significant event meeting or if more immediate action is required.

Significant Event Audit (SEA)

What is SEA?

Significant Event Audit (SEA) is an active approach to case analysis which involves the whole healthcare team in an open and supportive discussion of selected cases/incidents. It is not a new technique – doctors have long discussed cases for educational and professional purposes. The aim is to improve patient care by responding to incidents and allowing the healthcare team and, where appropriate, the support team to learn from them. The emphasis is on examining underlying systems, rather than directing inappropriate blame at individuals.

Such reflective practice is known by several names – significant event analysis, untoward incident analysis, critical event monitoring. The name itself is less important than the process and the outcomes derived from it.

It is likely that events identified will come from a variety of sources, for example, incidents that occurred in clinical, administrative or organisational areas, and patient complaints.

Collecting evidence

The nominated individual or their staff should collect factual information about the incident from those directly involved and any others who witnessed it. This might include patients (and their relatives, where appropriate). It is also important to review clinical records, and to identify any relevant policies and guidelines.

Confidentiality

Patient confidentiality must not be overlooked, particularly if information is to be submitted for local clinical audit. Patients should be informed that their data may be used in this way and given the opportunity to object. In general practice, patients can be informed through waiting room posters and practice leaflets. Normally it is appropriate to anonymise identifiable information before discussion.

Involving the team

Ideally, medical, nursing and other staff should be invited to the SEA meeting, as each will have a different perspective on the issues under discussion, which may help generate a variety of potential actions. In general practice you may wish to invite management and reception personnel. Attached staff, such as physiotherapists and pharmacists, can also be involved where relevant.

Occasionally, a clinical incident may be particularly sensitive and therefore inappropriate for discussion by the whole team. Often this issue can be avoided by anonymisation of patient information, but if a whole-team discussion is

inappropriate, the same review process can still take place with fewer participants.

The SEA meeting

We recommend that you set aside protected time for the discussion. It is helpful to have a chairperson with some experience in this type of process. This might be the nominated responsible individual.

The National Reporting and Learning Service (NRLS) suggests four questions are considered during the analysis.

1. What happened?
2. Why did it happen?
3. What has been learned?
4. What has been changed or actioned [5]?

The outcome

The process should result in positive change for the workplace and patients. The review can confirm good practice as well as identifying areas that need attention and more than one outcome can occur in the same case.

If no change is necessary this can be recorded, but if changes are to be made then you should:

- prioritise the changes to be made
- identify any training and skills required
- identify other resource implications, for example, purchasing of equipment
- devise a plan to meet these needs
- agree a timescale for change implementation
- nominate a person to be responsible for ensuring current practice is changed
- amend protocols/policies where necessary
- measure the effects of any improvements, where possible
- ensure review and feedback at future discussions – this can be done at the opening of the next SEA meeting.

SEA records

The purpose of the record is to provide a brief summary of the discussion and the lessons learned. The record should be updated once actions are completed so that the process is clear. We recommend that you keep completed anonymous SEA records as evidence of reflective practice for the purposes of appraisal and revalidation.

Sharing learning

It is vital to disseminate learning from incidents. Staff should be informed about any lessons learned and any proposals for change. If the feedback is constructive it should encourage staff to continue reporting incidents as they will see that information is being acted upon and that the system is being operated in a fair way.

You should also consider whether there is a requirement to report the event elsewhere, for example, to the NRLS or the CQC. Certain incidents, such as never events, have specific reporting requirements[6].

Further information

For doctors working in primary care, the NRLS has published a detailed guide to significant event audit[7].

If you work in the private sector or NHS secondary care you should check the specific policy at your place of work.

References

1. GMC, *Good Medical Practice* (2013), paragraph 55
2. GMC, *Good Medical Practice* (2013), paragraph 73
3. CQC, *Essential standards of Quality and Safety* (March 2010), outcome 16
4. BMA, *Quality and Outcomes Framework for 2012/13* (March 2012)
5. NRLS, *Significant event audit: guidance for primary care teams* (2008)
6. Current list of never events can be found on the Department of Health website at www.gov.uk/government/organisations/department-of-health
7. www.nrls.nhs.uk

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