

**Patient safety incident:** any unintended or unexpected occurrence that could have or did lead to harm.

**Significant event:** Any event thought by anyone in the team to be significant in the care of patients or the conduct of the practice

SEA is a 5 step process:

1. Awareness and prioritisation of a significant event.
2. Information gathering.
3. Analysis in a team meeting
4. Agree, implement and monitor change.
5. Report, share and review.

Step 1 a– Identify a patient safety incident (remember this can be an error that was prevented from causing harm)

**Describe the incident**

Step 2– Information gathering. Review the patient’s notes to describe the background information.

**Describe the background, the circumstances surrounding the incident**

Step 3– Hold your team meeting to analyse the incident

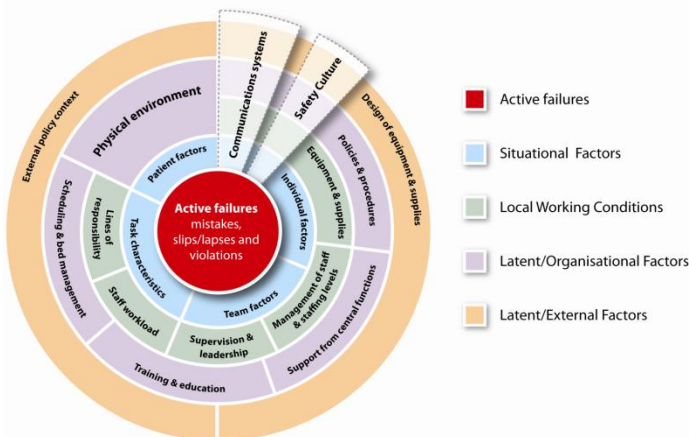
**Date the incident was identified**

**Date of the SEA meeting**

**Who is at the meeting?**

**Is the patient or their carer present?**

The Yorkshire Contributory Factors Framework



**Describe the most important of these contributory factors**



**Describe the lesson from this incident:**

## Step 4 – agree, implement and monitor change

Action	Which contributing factor does this action address	Who will do it	When will it be done by	How will we know when it's done	Progress	Date this action was completed

## Step 5 – Report , Share and Review

Date scanned into Patient records

Date reported to NRLS or CCG

Date shared with patient

Date for review of the effectiveness sustainability of the changes

