Improvement Academy

Part of the Yorkshire & Humber AHSN

GPs at SEA

A workshop for people conducting Significant Event Audit in General Practice

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Or visit our Academy Office: Bradford Institute for Health Research
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Objective

To be sufficiently equipped with the knowledge and tools needed to carryout Significant Event Audit (SEA) in a way that optimises the chances of improving patient safety.

What is a patient safety incident?

- Error [is when] a planned sequence of mental or physical activities fails to achieve its intended outcome…. James Reason
- A Patient Safety Incident is any unintended or unexpected incident that did or could have led to patient harm…. National Patient Safety Agency

Human Fallibility and the Inevitability of Error

Every time a human being touches something it's likely to go wrong.

James Reason

Stroop Effect Experiment

- In this illustration, you are required to say the **colour** of the word, not what the word says.

Test 1

RED	GREEN	BLUE	YELLOW	PINK
ORANGE	BLUE	GREEN	BLUE	WHITE
GREEN	YELLOW	ORANGE	BLUE	WHITE
BROWN	RED	BLUE	YELLOW	GREEN
PINK	YELLOW	GREEN	BLUE	RED

Test 1

RED	GREEN	BLUE	YELLOW	PINK
ORANGE	BLUE	GREEN	BLUE	WHITE
GREEN	YELLOW	ORANGE	BLUE	WHITE
BROWN	RED	BLUE	YELLOW	GREEN
PINK	YELLOW	GREEN	BLUE	RED

Test 2

- Selective perception test

www.**youtube**.com/watch?v=vJG698U2Mvo

Person Centred View

- The Perfection Myth:

  If I try harder I won't make a mistake.

- The Punishment Myth:

  If we punish a person who makes an error they won't make the error again.

- Johnsons Substitution test:

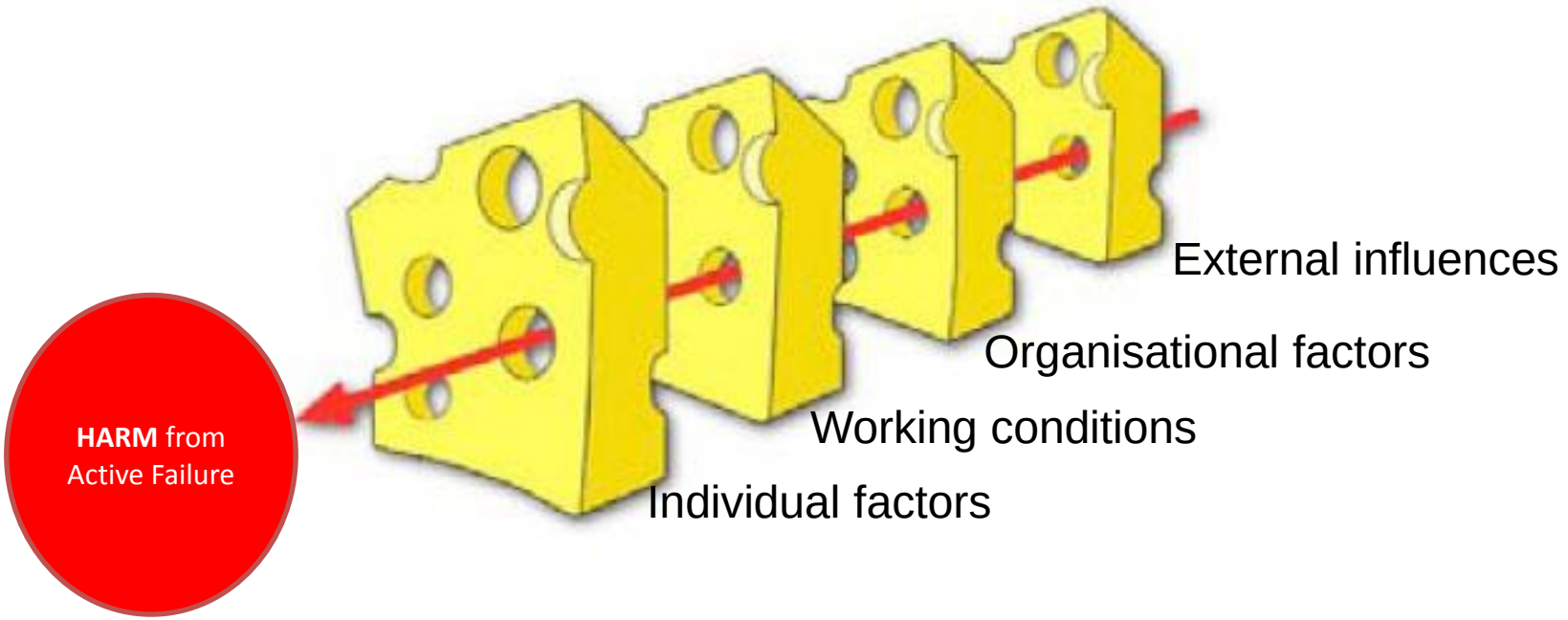
  Could some equally motivated, comparably qualified staff member have made the same error under similar circumstances?

Human Factors

Human Factors in healthcare is an approach to enhancing clinical performance through an understanding of the effects that teamwork, tasks, equipment, workspace, culture and organisation have on human behaviour and abilities.

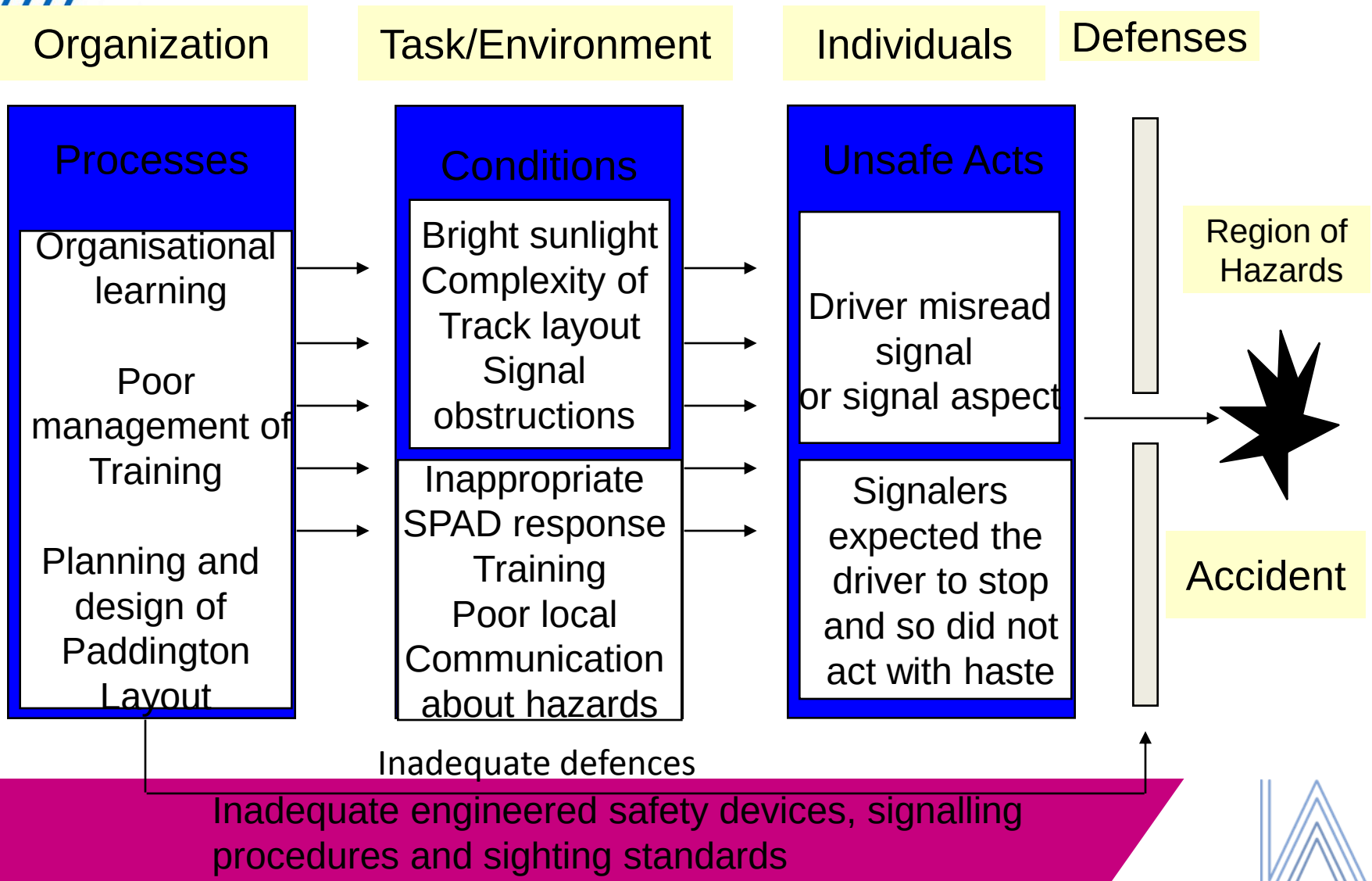
“Things that make it easier to do the right things, to the best of our ability”

Why it sometimes goes wrong. Systems Based Approach

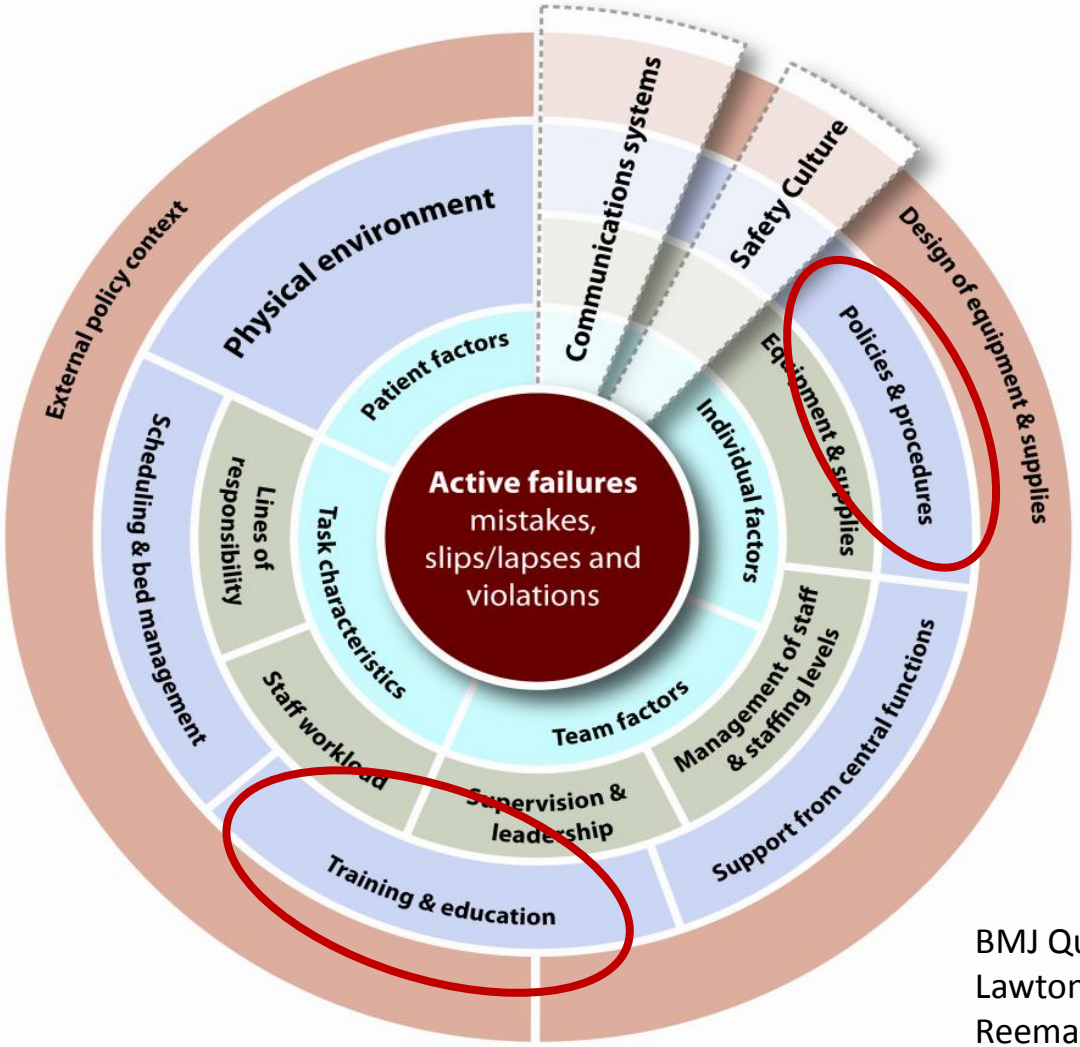


Representation of James Reason's Swiss Cheese Model

Ladbroke Grove train disaster (Lawton and Ward, 2005)



The Yorkshire Contributory Factors Framework, (Lawton et al, BMJ Q&S, 2012)



- Active failures
- Situational Factors
- Local Working Conditions
- Latent/Organisational Factors
- Latent/External Factors

BMJ Qual Saf 2012;21:369e380. Rebecca Lawton, Rosemary R C McEachan, Sally J Giles, Reema Sirriyeh, Ian S Watt, John Wright

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SEAisforSafety