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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www.improvementacademy.org

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

Objective

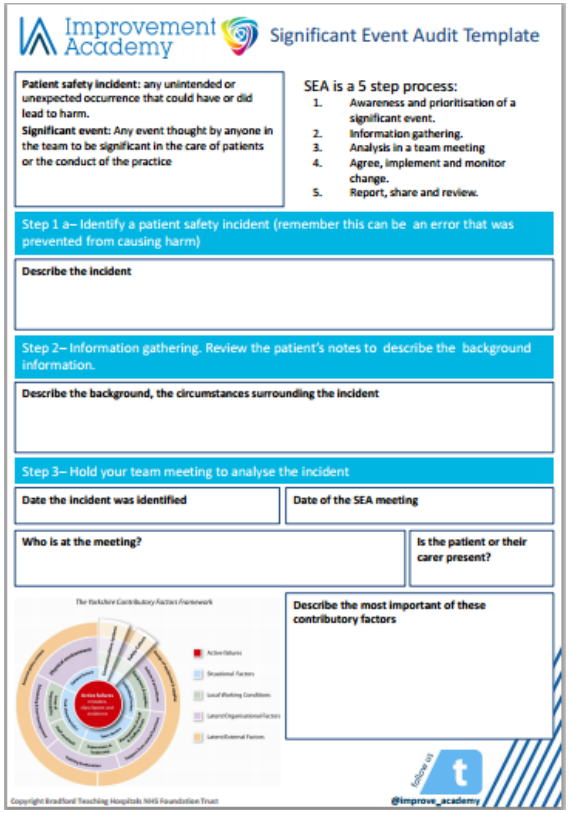
To be sufficiently equipped with the knowledge and tools needed to carryout Significant Event Audit (SEA) in a way that optimises the chances of improving patient safety.

Significant Event Audit - Benefits

"The best way to reduce harm is for the NHS to embrace wholeheartedly a culture of learning."*

*** A promise to learn – a commitment to act, The National Advisory Group on the Safety of Patients in England, chaired by Don Berwick, August 2013**

Significant Event Audit



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Significant Event Audit Template

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?

Describe the most important of these contributory factors

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

Involving patients

Significant event audit may be improved for both patient and practice if it includes the patient as a “witness” and “adviser”.

This is because of the emotional driver for change the patient brings.

Strictly Warfarin

Summary and close

1. Set the prioritisation process
2. Information gathering – what was the error?
3. What, why, why, why, because, so what?

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