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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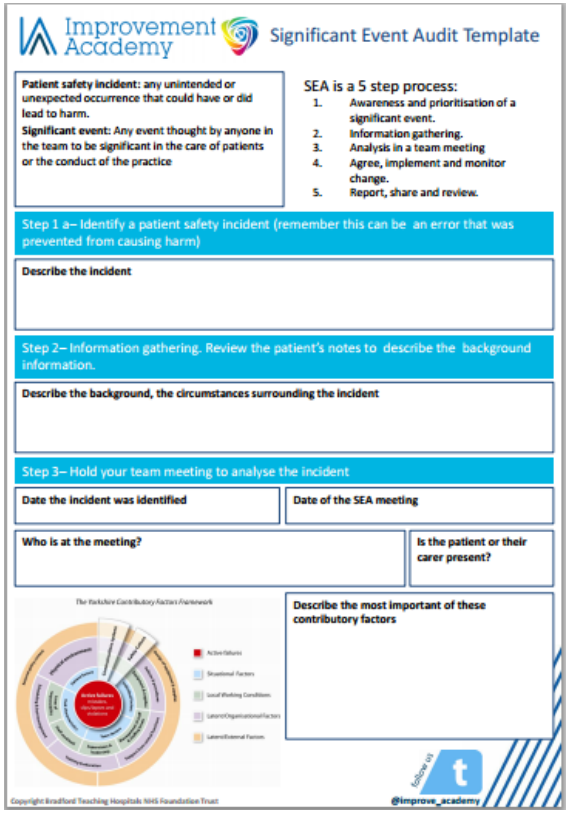
Housekeeping

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



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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.**

Step 4: What changes improve safety?

Task

- Stronger Actions
- Moderately strong actions
- Weaker actions

Step 4: What changes improve safety

Stronger

- Architectural / physical plant or equipment changes
- New device with usability testing before purchasing
- Engineering controls (interlock / forcing function)
- Simplify the process and remove unnecessary steps
- Standardise equipment or processes or care plans
- Tangible involvement and action by leadership in support of Patient Safety

Moderate

- Increase in staffing / decrease in workload
- Software enhancements / modifications
- Eliminate / reduce distractions
- Checklist / cognitive aid
- Eliminate look and sound-a-likes
- Enhanced documentation
- Enhanced communication

Weaker

- Double checks
- Warnings and labels
- New procedure / policy / Training
- Additional study / analysis
- Disciplinary action

Step 4: Challenges you may face and how to overcome them

SEA is an improvement activity
… so expect to be challenged

What challenges do you expect to hear?
And how will you reply?

Step 4: Model for Improvement

AIM → What are we trying to accomplish?

MEASURE → How will we know if a change is an improvement?

CHANGE → What changes can we make that will result in improvement?

RAPID CYCLE IMPROVEMENT →

Step 4: SEA examples to consider

Task

Look at the anonymised SEA

- Can the error be identified?
- Are contributory factors identified?
- Are the Actions suggested likely to improve the safety of patients?

Step 4: National Reporting and Learning System

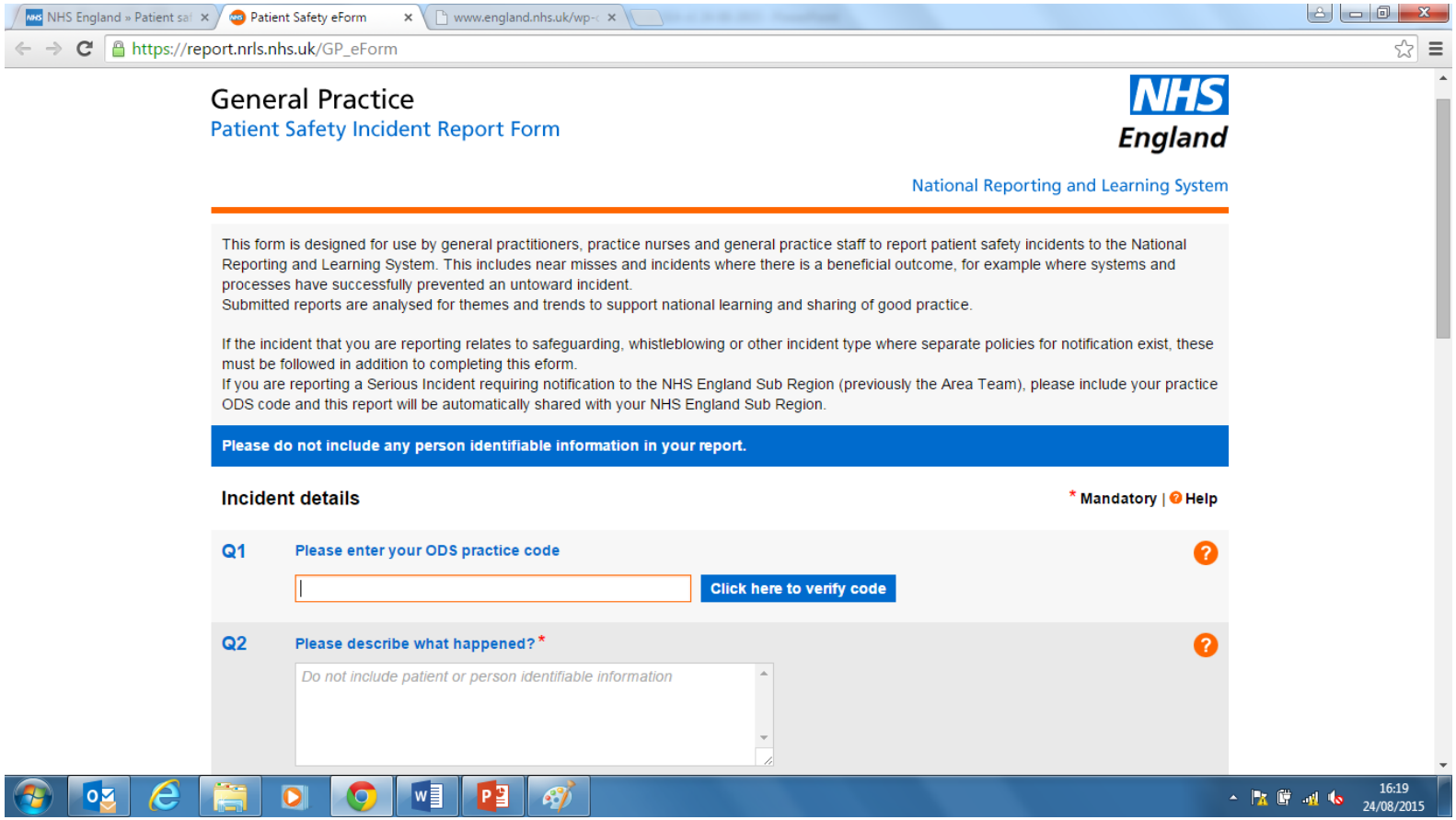
Reporting incidents onto NRLS supports nationwide analysis of patient safety concerns.

Reporting is easy. Using:

https://report.nrls.nhs.uk/GP_eForm

Feedback relies on locally managed systems.

Step 4: NRLS GP e-form



Step 5: Report and share and review

- Share completed SEA with the CCG
- Occasionally review SEA that were completed previously to see if the actions are still effective.
- Feedback from the CCG

Learn More

Improvement Academy Quality Improvement Training

http://www.improvementacademy.org/learning-events/

Improvement academy – Behaviour Change

http://bit.ly/1h4l2tr

Bradford Uni – PgCert in Patient Safety

http://bit.ly/1NXVCuC

More on request.

Summary and close

- Select a ‘moderately strong’ or ‘stronger’ barrier to error or harm
- Apply Human Factors – make things easier
- Manage resistance to change
- Test the change – Measure the change
- Roll out what works – dump what doesn’t

Contact Details

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