



# GPs at SEA

**A workshop for people conducting  
Significant Event Audit in General Practice**

e: [academy@yhahsn.nhs.uk](mailto:academy@yhahsn.nhs.uk) / t: 01274 383926

[www.improvementacademy.org](http://www.improvementacademy.org)

Or visit our Academy Office: Bradford Institute for Health Research  
Temple Bank House / Duckworth Lane / Bradford / BD9 6RJ



# 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

**Improvement Academy** 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?

The Riskfactor Contributory Factors Framework

Describe the most important of these contributory factors

Copyright: Bradford Teaching Hospitals NHS Foundation Trust  
@improve\_academy

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](https://report.nrls.nhs.uk/GP_eForm)

Feedback relies on locally managed systems.



# Step 4: NRLS GP e-form

The screenshot shows a web browser window with the URL [https://report.nrls.nhs.uk/GP\\_eForm](https://report.nrls.nhs.uk/GP_eForm). The page title is "General Practice Patient Safety Incident Report Form". The NHS England logo is in the top right corner, with the text "National Reporting and Learning System" below it.

This form is designed for use by general practitioners, practice nurses and general practice staff to report patient safety incidents to the National Reporting and Learning System. This includes near misses and incidents where there is a beneficial outcome, for example where systems and processes have successfully prevented an untoward incident. Submitted reports are analysed for themes and trends to support national learning and sharing of good practice.

If the incident that you are reporting relates to safeguarding, whistleblowing or other incident type where separate policies for notification exist, these must be followed in addition to completing this eform.

If you are reporting a Serious Incident requiring notification to the NHS England Sub Region (previously the Area Team), please include your practice ODS code and this report will be automatically shared with your NHS England Sub Region.

**Please do not include any person identifiable information in your report.**

**Incident details** \* Mandatory | Help

**Q1** Please enter your ODS practice code ?

[Click here to verify code](#)

**Q2** Please describe what happened? \* ?

*Do not include patient or person identifiable information*

The bottom of the screenshot shows a Windows taskbar with icons for Internet Explorer, Outlook, Edge, File Explorer, VLC, Chrome, Word, PowerPoint, and Paint. The system tray shows the time as 16:19 on 24/08/2015.



## 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



twitter

@Improve\_Academy

[www.improvementacademy.org](http://www.improvementacademy.org)

t: 01274 383926

e: [academy@yhahsn.nhs.uk](mailto:academy@yhahsn.nhs.uk)



Improvement  
Academy

