Significant Event Audit

NHS
National Patient Safety Agency

National Reporting and Learning Service

A quick guide to conducting a Significant Event Audit

Conducting an effective Significant Event Audit (SEA) allows you and your team to highlight and learn from both strengths and weaknesses in the care you provide.

Improving the quality and safety of patient care is a key clinical governance priority in primary healthcare and SEA has an important role in contributing to this aim.

This quick guide to conducting an effective SEA will help you and your team improve care for all your patients.

The seven stages of Significant Event Audits

Stage 1 – Awareness and prioritisation of a significant event

Staff should be confident in their ability to identify and prioritise a significant event when it happens. The practice should be fully committed to the routine and regular audit of significant events.

Stage 2 – Information gathering

Collect and collate as much factual information on the event as possible from personal testimonies, written records and other healthcare documentation. For more complex events, an in-depth analysis will be required to fully understand causal factors.

Stage 3 – The facilitated team-based meeting

The team should appoint a facilitator who will structure the meeting, maintain basic ground rules and help with the analysis of each event. The team should meet regularly to discuss, investigate and analyse events. These meetings are often the key function in co-ordinating the SEA process and they should be held in a fair, open, honest and non-threatening atmosphere.

Agree any ground rules before the meeting starts to reinforce the educational spirit of the SEA and ensure opinions are respected and individuals are not 'blamed'.

Minutes of the meeting should be taken and action points noted. These should be sent to all staff, including those unable to attend the meeting.

An effective SEA should involve detailed discussion of each event, demonstration of insightful analysis, the identification of learning needs and agreement on any action to be taken.

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Stage 4 – *Analysis of the significant event*

The analysis of a significant event can be guided by answering four questions:

1. What happened?
2. Why did it happen?
3. What has been learned?
4. What has been changed or actioned?

The possible outcomes may include:

- no action required;
- a celebration of excellent care;
- identification of a learning need;
- a conventional audit is required;
- immediate action is required;
- a further investigation is needed;
- sharing the learning.

Stage 5 – *Agree, implement and monitor change*

Any agreed action should be implemented by staff designated to co-ordinate and monitor change in the same way the practice would act on the results of 'traditional' audits.

Progress with the implementation of necessary change should always be monitored by placing it on the agenda for future team or significant event meetings.

Where appropriate, the effective implementation and review of change is vital to the SEA process. To test how well the SEA process has gone, practices should ask themselves 'What is the chance of this event happening again?'.

Stage 6 – *Write it up*

It is important to keep a comprehensive, anonymised, written record of every SEA, as external bodies will require evidence that the SEA was undertaken to a satisfactory standard. The SEA report is a written record of how effectively the significant event was analysed.

Stage 7 – *Report, share and review*

Reporting when things go wrong is essential in general practice. The practice should formally report (either to the National Reporting and Learning Service, or via the primary care trust/ healthcare organisation) those events where patient safety has, or could have been, compromised.

Where a mechanism exists, practices should share knowledge of important significant events with local clinical governance leaders so that others may learn from these.

To download the full guidance on SEA go to www.npsa.nhs.uk/nrls/gp

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