Significant Event Audit

Synonyms: critical event audit, critical incident analysis, structured case analysis, facilitated case discussion

Significant event audit (SEA) has been defined as occurring when "individual cases in which there has been a significant occurrence (not necessarily involving an undesirable outcome for the patient) are analysed in a systematic and detailed way to ascertain what can be learnt about the overall quality of care and to indicate changes that might lead to future improvements". [1]

Significant events can be very wide-ranging and can reflect good as well as bad practice. Examples could include underage pregnancy, coping with a staffing crisis, complaints or compliments received by the practice, breaches of confidentiality, a sudden unexpected death or hospitalisation, an unsent referral letter, a person with diabetes registered as severely sight impaired or a delay in cancer diagnosis.

Unlike the bulk of clinical audit in General Practice, SEA is qualitative and requires a skilled, structured dissection of events, whether clinical, administrative, or organisational, around some central, crucial questions:

- What happened and why?
- How could things have been different?
- What can we learn from what happened?
- What needs to change?

As with more conventional audit cycles, there is no fixed end point; outcomes should be revisited and the implementation and success of any agreed changes monitored at preset intervals.

Aims of SEA [2]

- To identify events in individual cases that have been critical (beneficial or detrimental to the outcome) and to improve the quality of patient care from the lessons learnt.
- To instigate a culture of openness, not individual blame or self-criticism, and reflective learning.
- To enable team-building and support following stressful episodes.
- To enable identification of good practice, as well as suboptimal.
- To be a useful tool for team and individual continuing professional development, identifying group and individual learning needs.
- To share SEA between teams within the NHS where adverse events occur at the 'overlap' or in shared domains of clinical responsibility - eg, out-of-hours (OOH), discharge problems.

Epidemiology

Medical error in primary care is believed to occur at a rate of between 5-80 times per 100,000 consultations. Prescribing and prescription errors occur in up to 11% of all prescriptions, mainly related to dosage. [3] A quarter of patients experience an adverse event within four weeks of starting a medicine, of which 11% are considered preventable. [4]

Process

SEA stages

There are seven stages to an SEA, encompassing the following: [2] [5]

- Awareness of and prioritising a significant event.
- All members of staff being able to identify and prioritise a significant event confidently.
- Practices having a simple computer-based or paper-based system for logging all significant events as they occur. This should be easily accessible to all staff.

- Significant events being prioritised on the basis of their actual, or potential, consequences for the quality and safety of patient care. There should also be clearly apparent opportunities for learning and improvement.
- Often there is an over-representation of heavily clinical material for audit which may be alienating for non-clinical staff, so flexibility is required, meeting in different team combinations appropriate to the nature of the events and reporting back to a future, full team-based meeting.

Information gathering

- As much factual information should be gathered as possible including:
    - Medical records and other clinical data - eg, case records, laboratory reports, letters, protocols.
    - Personal accounts of the patient, relatives, healthcare staff, and other involved agencies (note that these will reflect thoughts, opinions and impressions).

- The information should be collated to enable a timeline of the event and further analysis.

Afacilitated team-based meeting

- Usually this occurs as a dedicated, regular meeting or is given protected time as part of regular team meetings. Serious events may warrant a specially convened meeting as soon as possible after the event. Sufficient time should be scheduled: discussion length will vary, but between 20 and 45 minutes will generally be needed for each case and, for more emotive topics, up to an hour may be needed.
- Group size is important. Whilst it is important to have all involved team members present, large groups tend to function less well than small groups.
- The selection of time, duration and setting of the meeting is also important. Acomfortable, quiet room is essential. Holding the discussions during the day makes it easier for all staff to attend but it can be difficult to avoid routine interruptions. Consider rotating the day on which meetings are held, to prevent routine exclusion of some part-time members of staff.
- Successful SEArequires an honest, open and non-threatening atmosphere with respect, confidentiality and 'no blame' ground rules agreed in advance. Individual feedback needs to be positive, fair, constructive and sensitive.
- Afacilitator should be selected from within the practice team, although an external facilitator may have merits in certain situations. Strong leadership is vital but it is important also to be conscious of any perceived 'hierarchy' (eg, administrative staff vs professional staff, partners vs salaried doctors) which may impede confident and open participation. The facilitator's role includes structuring discussion, maintaining ground rules, acknowledging emotion and, where possible, remaining outside the group, avoiding collusion, etc.
- Each topic/event should be presented by the key person with description of what first occurred, the subsequent events, and why they perceived the incident to be an example of effective or ineffective practice, followed by more general discussion.[1]
- Minutes and recording of agreed learning and action points should take place and copies should be circulated following the meeting.

The analysis of the significant event

- What happened?
    - Establish a detailed account using all the evidence that had been previously gathered. Also, consider the impact of the event for the patient, professionals involved individually or as a team and for the organisation.

- Why did it happen?
    - Critically establish the main and underlying reasons that contributed to the event happening. Try not to focus on superficial causes of events - for example, 'I forgot to pass on an important message' may superficially explain an event, but does not reveal systems and organisational contributory causes such as understaffing, lack of effective message systems, and interruptions.

- What has been learned?
    - Reflection and learning must be demonstrated both at an individual and a team level. Consider educational and training needs, reinforcement/change in systems or protocols, changes in team working and communication.

- What has been changed or actioned?
    - Outcomes could include celebrating excellent care, identifying learning needs, the need for a conventional audit, immediate action to rectify problems or the need for further investigation where there is lack of resolution or sharing learning more widely. Occasionally no action is an appropriate outcome where SEA has been an appropriate venue for staff to air frustrations without requiring systems change - eg, 'life's like that but I feel better for talking about it.'

Agreement, implementation and monitoring of necessary change

- Return to past minutes at the start of future meetings to review and monitor change.
- Staff should have been identified to co-ordinate and monitor change and a realistic timescale for change agreed.
- Actions and outcomes should be reviewed to establish that change is occurring and being sustained.
- Ask, 'What is the chance of this event happening again?'.

Documentation

- Record the key points of the investigation and analysis in a systematic way - standardised proformas are widely used. Pay attention to any action points agreed and those agreeing to implement/oversee change.
- The written report is the permanent record of the entire SEA process so it needs to be comprehensive and anonymised. Reports can be updated as actions are carried out or outcomes achieved.
- External bodies that may require access to SEA reports include patients and carers, educational peer reviewers, Quality and Outcomes Framework (QOF) assessors, GP appraisers, clinical governance committees, clinical commissioning groups (CCGs) and the General Medical Council (GMC) for future revalidation.

Wider reporting, sharing and reviewing of important SEAs

- Reporting significant events, particularly 'near misses', is important to preventing future harm to patients in other settings. Events leading to a serious outcome are more likely to be flagged up by existing clinical governance and reporting systems. Patterns of events allow organisational or cultural factors impacting on safety to be recognised. Increasingly, practices will be required to report a proportion of significant events.
- The Patient Safety Agency (PSA) acts to report and analyse adverse incidents and 'near misses' within the NHS, as well as assimilating lessons and producing solutions to prevent repeated, similar adverse events. [6]
- In the past, reporting has been very limited within primary care and fragmentary due to a host of reporting mechanisms to different organisations. GPs are now encouraged to report and share SEAs via their local CCG clinical governance leads and PSA's National Reporting and Learning Service. There remain a number of other systems - eg, the Medicines and Healthcare products Regulatory Agency's (MHRA) Yellow Card Scheme for adverse medical events. [7]

Difficulties and barriers to the process need to be anticipated. Consider and address:

- Time restrictions, including the need sometimes for debriefing sessions.
- Difficulties with being sufficiently honest.
- Potential for emotionally demanding and sometimes uncomfortable experiences.
- Group dynamics and leadership styles.
- Conflicted loyalties for externally employed staff.
- Motivation.
- Concerns about issues of confidentiality or fears of increasing the risk of litigation.
- Lack of challenge and insularity of performing SEA within a practice.

Historical background

The technique of SEA is based on work on the critical incident technique developed during World War II by an aviation psychologist called Flanagan, to identify successful and non-successful aspects of combat leadership which could then be applied to training.[8] Its use has been extended far beyond this field to, for example, business, healthcare, organisational psychology and education. The SEA's focus on the team rather than the individual is a key difference compared with critical incident technique.[9]

Forms of significant event analysis existed within the NHS prior to the uptake of SEA, including the traditional grand round, clinical-pathology meetings, morbidity and mortality meetings and the various Confidential Inquiries. These all tend to focus on failures and to be based on more traditional hierarchical structures and inquisition.

A key concern of the modern NHS has been the improvement of quality and reduction of risk of harm to patients. Clinical governance was instituted in April 1999 in the wake of the publication of 'A First Class Service'.[10] This was followed by other important governmental documents, including:

- The Chief Medical Officer's 'An Organisation With a Memory'.[11]
- The Department of Health's 'Building a Safer NHS for patients', which identified opportunities for improving patient safety.[12]

SEA has been strongly promoted as a means of delivering many aspects of clinical governance.

Since 2004, SEA has been part of the Quality and Outcomes Framework (QOF) as one of the organisational indicators. Increasingly, proof of involvement in SEA and of reflective learning based on it, is being demanded in appraisal and potentially for future revalidation of individual GPs. Current proposals for revalidation suggest evidence of at least five SEAs which will be required as part of the revalidation portfolio, and that these will need to reflect cases in which an individual GP has had direct involvement, where discussion has occurred as part of a team meeting and where the GP is directly involved in any changes (or implementing of change) suggested.[13]

SEA has been widely taken up across UK primary care, driven by contractual and appraisal demands, despite a current lack of evidence demonstrating its efficacy at delivering improved patient care and safety and its reliability across different settings for investigating serious or complex safety issues.[14] Indeed, the PSA has recommended that whilst primary care teams perform SEA as part of their safety culture for significant events of low-to-moderate severity, an alternative, more exhaustive method known as root cause analysis (RCA) should be used for events occasioning severe harm or death.[15] One review showed that learning opportunities are identified in over 95% of SEAs, with 80% describing actions taken to improve practice systems or professional behaviour.[3] Whether or not reported change leads to sustained change and improved patient safety long-term is uncertain. The use of external peer feedback (eg, in appraisals) could be used to model and improve the use of SEA in primary care.[16]

Further reading & references

1. Gillam S, Siriwardena AN; Frameworks for improvement: clinical audit, the plan-do-study-act cycle and significant event audit. Qual Prim Care. 2013;21(2):123-30.
2. Significant Event Audit; University of Exeter
3. Sandars J, Esmail A; The frequency and nature of medical error in primary care: understanding the Fam Pract. 2003 Jun;20(3):231-6.
4. Royal S, Smeaton L, Avery AJ, et al ; Interventions in primary care to reduce medication related adverse events and hospital admissions: systematic review and meta-analysis. Qual Saf Health Care. 2006 Feb;15(1):23-31.
5. Significant Event Audit; NHS Patient Safety Agency
6. Patient Safety; NHS Patient Safety Agency
7. Online reporting site for the Yellow Card Scheme; Medicines and Healthcare products Regulatory Agency (MHRA)
8. Flanagan JC; The critical incident technique. Psychol Bull. 1954 Jul;51(4):327-58.
9. McKay J, Bradley N, Lough M, et al; A review of significant events analysed in general practice: implications for the BMC Fam Pract. 2009 Sep 1;10:61.
10. A first class service: quality in the new NHS; Dept of Health, July 1998
11. An organisation with a memory; Dept of Health, June 2000
12. Building a safer NHS for patients - implementing an organisation with a memory; Dept of Health, April 2001
13. Revalidation Guidance for GPs; Royal College of General Practitioners (RCGP)
14. Bowie P, Pope L, Lough M; A review of the current evidence base for significant event analysis. J Eval Clin Pract. 2008 Aug;14(4):520-36. Epub 2008 May 2.
15. Seven steps to patient safety in general practice; NHS Patient Safety Agency, June 2009

16. McKay J, Shepherd A, Bowie P, et al; Acceptability and educational impact of a peer feedback model for significant Med Educ. 2008 Dec;42(12):1210-7.

Original Author:	Current Version:	Peer Reviewer:
Dr Chloe Borton	Dr Roger Henderson	Dr Helen Huins
Last Checked:	Document ID:	© EMIS
29/08/2014	2781 (v22)	