Significant Event Analysis
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Stupidity: Doing the same thing over and over and expecting a different result
Aims and Objectives

To provide participants with an overview of Significant Event Analysis and how this tool can be used within the practice to improve the quality of care and training aids.
Learning Outcomes

• Define what is meant by a significant event
• Discuss how Significant Event Analysis can be used as a learning tool within practice
• Carry out Significant Event Analysis within your practice setting
What do we mean by a ‘significant’ event?

“Any event thought by anyone in the health care team to be significant in the care of patients or the conduct of the practice or organisation” (Pringle et al. 1995)

Oxford English Dictionary definition of significant:

“Extensive or important enough to merit attention”
What is Significant Event Analysis (SEA)?

"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".

Significant Event & Other Similar Terms

Significant event is an umbrella term

- Near Miss (Incident)
- Adverse Event (Accident)
- Error
- Good Practice
Near misses 30,000/year in the aviation industry worldwide....how many in dentistry?
Errors and Accidents

Medical Errors Cost US $8.8 Billion, Result in 238,337 Potentially Preventable Deaths between 2004-2006

*ScienceDaily (Apr. 8, 2008)*

That is more than the combined number in the US who die in road traffic accidents, air accidents, falls, suicides and drownings!
Good Practice
A good SEA will:

- Be relevant
- Be a lifelong learning tool
- Be carried out in a no blame environment
Examples of Dental Significant Events

Door blows off of autoclave and embeds in the wall!
Patient becomes aggressive and throws a chair across the waiting room.

Patient dies of heart attack – correct protocol is followed
Latex gloves worn for latex-sensitive patient.

Irrigation needle causes inoculation injury.
1kg jar of mercury falls out of window smashing in neighbour’s garden

Patient trips down stairs.

Wrong tooth for extraction marked on lab ticket – denture is made as an immediate.

Wall-mounted x-ray machine becomes detached from the wall.

X-ray machine keeps buzzing as if patient is being given overdose, isolation switch difficult to reach.

Dental light explodes! (Same practice as the autoclave)!!
The Seven Steps to SEA!

Step 1 – Identify your significant event
Step 2 – Collect and collate as much information as possible relating to the event
Step 3 – Convene a meeting – non-threatening, no blame, egalitarian – educational focus
Step 4 – Undertake a **structured** analysis
Step 5 – Monitor progress of all actions agreed upon
Step 6 – Write up the event analysis
Step 7 – Seek educational feedback – peer review
Identifying a Significant Event

Significant Events should be prioritised for audit based on their consequences (actual or potential) for the quality and safety of patient care.

Bowie et al, Significant Event Audit
Guidance for Primary Care Teams
NES framework for the structured analysis of a significant event

1. **What happened?**
   Describe what actually happened in detail and chronological order. Consider, for instance, how it happened, where it happened, who was involved and what the impact or potential impact was on the patient, the team, organisation and/or others.

2. **Why did it happen?**
   (Describe the main and underlying reasons – both positive and negative – contributing to why the event happened. Consider, for instance, the professionalism of the team, the lack of a system or a failing in a system, lack of knowledge or the complexity and uncertainty associated with the event).

3. **What has been learned?**
   (Demonstrate that reflection and learning have taken place on an individual or team basis and that relevant team members have been involved in the analysis of the event. Consider, for instance: a lack of education & training; the need to follow systems or procedures; the vital importance of team working or effective communication).

4. **What has been changed?**
   (Outline the action(s) agreed and implemented, where this is relevant or feasible. Consider, for instance: if a protocol has been amended, updated or introduced; how was this done and who was involved; how will this change be monitored. It is also good practice to attach any documentary evidence of change e.g. a letter of apology to a patient or a new protocol).

Lough, 2003
Brief Summary - Dental Example of SEA

• **What happened** – Busy dental practice had a good, thorough protocol in place. Dentist failed to notice from the medical history that the patient was latex sensitive (acutely). Was about to carry out procedure when he realised he was wearing latex gloves.

• **Why did it happen** – Medical history was correctly updated, dentist was particularly busy and had failed initially to notice the warning.

• **What has been learned** – Need to check patient’s medical history and act upon it. How easy safety can potentially be compromised. Dentist concerned that although robust protocol in place there was still room for human error.

• **What was changed** – Practice adopted latex-free policy and amended their protocol accordingly.
Aggressive patient throws chair across waiting room

Example of a Structured Event Analysis – In brief

WHAT HAPPENED?

- A teenage male patient became angry and unreasonable. He resisted efforts by his mother to get him to follow the dental nurse in to the dental surgery.

- In a fit of anger, the angry patient threw a chair across the waiting room narrowly missing a member of staff.

- **Potential impact:** The member of staff could have been injured as could a waiting patient. Even the aggressive patient could have been hurt.
Example of a Structured Event Analysis –
WHY DID IT HAPPEN?

Team-based SEA established:

• The practice did not have a policy or protocol for dealing with aggressive patients.

• No member of staff knew how to act in the face of this aggressive behaviour.

• The patient was extremely nervous and his reaction to waiting for a long time was aggression.
Example of a Structured Event Analysis –
WHAT WAS LEARNED?

• A practice policy and protocol on dealing with aggressive patients was required.

• It was recognised that this was not an isolated incident and that further training for staff in handling aggression was required.

• Staff recognised that certain behaviour on their part could limit the likelihood of aggression
Example of a Structured Event Analysis – WHAT WAS CHANGED?

• A policy and protocol on dealing with aggression was written and every member of the team was made aware of it.

• An audit on incidents involving aggressive behaviour was carried out.

• The practice protocol was displayed prominently

• Training was organised for staff in dealing with and where possible avoiding aggression.
Peer Review and Developmental Feedback
What do we mean by Peer Review?

• Peer review is the critical evaluation of a specific aspect of a practitioner’s performance by professional colleagues using a valid and reliable instrument to facilitate developmental feedback.

• The process is educational and concerned with improvement where this is required

• Fair, positive, constructive and sensitive
Why do we need Peer Review?

Taking Clinical Audit/SEA as examples:

- **Compulsory** activity for all health care professionals as part of the Clinical Governance Agenda. Nowadays you must be able to **demonstrate** a good standard of care.
- Will become even more relevant with **revalidation**.
- **False assumption** that health care professionals intuitively understand and can apply audit methods.
- Lack of knowledge: **poor design**, inconsistencies in approach, fail to implement & evaluate change, high incompletion rate.
- **Missed opportunities** to improve patient care and safety.
Educational Peer Review Model in the West of Scotland

- Developed by NES (general practice) in late-1990s in recognition of barriers and difficulties in applying and undertaking CPD activities to a satisfactory standard.
- Purpose is to promote CPD activity and act as a provider of educational feedback on whether performance could be improved or enhanced.
- Voluntary, confidential and based on educational principles - written feedback on improvement provided by informed and trained peers.
- Around 1/3 of GPs in west of Scotland have participated.
- Pharmacy and Dental professions in NHS Scotland (2006) – SEA.
How the Model works for SEA

- SEA submitted to NES in standard report format by member of health care team.
- Anonymised
- Sent to two trained Peer Assessors who independently review the report using a content valid feedback instrument.
- Developmental educational feedback collated and sent to submitting individual for their consideration.
SEA & Peer Review

- SEA viewed positively as a flexible, problem solving tool which enhances team-working and improves communication.
- Perceived as a reflective learning mechanism which can be used in learning needs assessment and in dealing with complaints.
- Cathartic element – may lead to closure.
- Successful SEA peer review can lead to increased work satisfaction, and professional reassurance.
Potential Pitfalls

Lack of Detail – Four sentences!!
Illegible Report – Type it to avoid this
Lack of Relevance
Follow the Seven Steps
Further Pitfalls

Staff perspective should be mentioned
Patient perspective – could be challenging
Implications both +ve and –ve for staff/patients/practice
What changes
Minutes of meeting not added
Has the change had the desired effect
Did it require staff training? If so what?
Who was delegated to lead the change?
Revalidation

"Ha, ha! — Made you look!"
What is involved?

GDC will look at 4 areas (domains)

- Professionalism
- Clinical
- Communication
- Management and Leadership
Three Stage Process

• Sifting – dentists will be required to produce a portfolio of evidence
• Assessment of Selected Professionals
• In-Depth Assessment
Sources of Evidence

- **Audit/Peer Review**
- Multi-Source Feedback
- Patient Satisfaction Surveys
- Personal and Practice Development Plans
- CPD Compliance
- Anonymised Patient Records
- Practice Accreditation Schemes
- **Significant Event Analysis**
- Practice policies, procedures and patient info leaflets
- Appraisal
The GDC will then use a points system to determine whether the portfolio of evidence is suitable to allow revalidation or should the person then move to Stage 2 (Assessment of selected professionals)
Any Questions?