

# Significant event analyses (SEA)

## Recommendations in facilitating the structured analysis of a significant event

### 1. What happened?

- Collate and record as much factual information as possible about the event including, for example, what happened, when and where, what was the outcome and who was involved.
- Record the thoughts and opinions of those involved, including patients and relatives if appropriate, and attempt to form an accurate impression of what happened.

### 2. Why did it happen

- Ensure the main reasons why the event occurred are fully established and recorded, e.g. was it a failure in a practice system or a failure to adhere to a protocol?
- Establish the underlying or contributory reasons as to why the event occurred e.g. *why* was there a failure in a practice system or adherence to a protocol?

### 3. What has been learned?

- Agree and record the main learning issues for the practice team or individual members of the team.
- Ensure that insight into the event has been established by the practice team or the individual members of the team
- Ensure that insight into the event has been established by the practice team or the individuals concerned.

### 4. What has been changed?

- Agree and implement appropriate action in order to minimise the chances of the event recurring, where change is considered to be relevant.
- Monitor the implementation of any change introduced.

**Please rate the level of evidence contained in the SEA report for each of the following**  
 (using the rating scale where 1=Absent and 7=Excellent):

<p><b>1. The description of what actually happened</b></p> <p>Comments:</p>	<p align="center"> <b>1</b>   <b>2</b>   <b>3</b>   <b>4</b>   <b>5</b>   <b>6</b>   <b>7</b>  <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>            Absent   Poor   Good   Excellent         </p>
<p><b>2. The role(s) of all individual(s) involved in the events has been described:</b></p> <p>Comments:</p>	<p align="center"> <b>1</b>   <b>2</b>   <b>3</b>   <b>4</b>   <b>5</b>   <b>6</b>   <b>7</b>  <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>            Absent   Poor   Good   Excellent         </p>
<p><b>3. The setting(s) where the event happened has been described:</b></p> <p>Comments:</p>	<p align="center"> <b>1</b>   <b>2</b>   <b>3</b>   <b>4</b>   <b>5</b>   <b>6</b>   <b>7</b>  <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>            Absent   Poor   Good   Excellent         </p>
<p><b>4. The underlying reason(s) why the event happened has been described:</b></p> <p>Comments:</p>	<p align="center"> <b>1</b>   <b>2</b>   <b>3</b>   <b>4</b>   <b>5</b>   <b>6</b>   <b>7</b>  <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>            Absent   Poor   Good   Excellent         </p>
<p><b>5. The impact or potential impact of the event has been described:</b></p> <p>Comments:</p>	<p align="center"> <b>1</b>   <b>2</b>   <b>3</b>   <b>4</b>   <b>5</b>   <b>6</b>   <b>7</b>  <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>            Absent   Poor   Good   Excellent         </p>
<p><b>6. Reflection on the event has been demonstrated:</b></p> <p>Comments:</p>	<p align="center"> <b>1</b>   <b>2</b>   <b>3</b>   <b>4</b>   <b>5</b>   <b>6</b>   <b>7</b>  <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>            Absent   Poor   Good   Excellent         </p>
<p><b>7. Learning from the event has been demonstrated:</b></p> <p>Comments:</p>	<p align="center"> <b>1</b>   <b>2</b>   <b>3</b>   <b>4</b>   <b>5</b>   <b>6</b>   <b>7</b>  <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>            Absent   Poor   Good   Excellent         </p>
<p><b>8. Appropriate action has been taken (where relevant or feasible):</b></p> <p>Comments:</p>	<p align="center"> <b>1</b>   <b>2</b>   <b>3</b>   <b>4</b>   <b>5</b>   <b>6</b>   <b>7</b>  <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>            Absent   Poor   Good   Excellent         </p>
<p><b>9. Where possible, appropriate individual(s) have been involved in the analysis of the significant event:</b></p> <p>Comments:</p>	<p align="center"> <b>1</b>   <b>2</b>   <b>3</b>   <b>4</b>   <b>5</b>   <b>6</b>   <b>7</b>  <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>            Absent   Poor   Good   Excellent         </p>

## References

- Bowie, P., S. McCoy, et al. (2005). "Learning issues raised by the educational peer review of significant event analyses in general practice." Quality in Primary Care **13**(2): 75-83.
- Bowie, P., J. McKay, et al. (2004). "Awareness and analysis of a significant event by general practitioners: a cross sectional survey." Quality & safety in health care **13**(2): 102-107.
- Bowie, P., L. Pope, et al. (2008). "A review of the current evidence base for significant event analysis." Journal of Evaluation in Clinical Practice **14**(4): 520-536.
- De Wet, C., N. Bradley, et al. (2010). "Significant event analysis: a comparative study of knowledge, process and attitudes in primary care." J Eval Clin Pract.
- McKay, J., D. J. Murphy, et al. (2007). "Development and testing of an assessment instrument for the formative peer review of significant event analyses." Quality & safety in health care **16**(2): 150-153.
- Woloshynowych, M., S. Rogers, et al. (2005). "The investigation and analysis of critical incidents and adverse events in healthcare." Health Technology Assessment **9**(19): 1-+.