**Significant Event Policy**

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**Table of contents**

[1 Introduction 3](#_Toc514323296)

[1.1 Policy statement 3](#_Toc514323297)

[1.2 Principles 3](#_Toc514323298)

[1.3 Status 3](#_Toc514323299)

[1.4 Training and support 3](#_Toc514323300)

[2 Scope](#_Toc514323301) 4

[2.1 Who it applies to](#_Toc514323302) 4

[2.2 Why and how it applies to them 4](#_Toc514323303)

[3 Definition of terms 4](#_Toc514323304)

[3.1 Patient safety 4](#_Toc514323305)

[3.2 Patient safety incident 4](#_Toc514323306)

[3.3 Incident 4](#_Toc514323307)

[3.4 Near miss 4](#_Toc514323308)

[3.5 Significant event](#_Toc514323309) 5

[3.6 Significant event analysis 5](#_Toc514323310)

[3.7 Care Quality Commission 5](#_Toc514323311)

[4 Significant event analysis 5](#_Toc514323312)

[4.1 Rationale 5](#_Toc514323313)

[4.2 Involving the team 5](#_Toc514323314)

[4.3 Aims of SEA 5](#_Toc514323315)

[4.4 What constitutes a SEA? 6](#_Toc514323316)

[4.5 Benefits of significant event analysis 6](#_Toc514323317)

[4.6 Reporting advice 6](#_Toc514323318)

[5 Demonstrable evidence](#_Toc514323319) 7

[5.1 CQC inspections](#_Toc514323320) 7

[6 Recording significant events 8](#_Toc514323321)

[6.1 Template usage 8](#_Toc514323322)

[6.2 Practice lead 8](#_Toc514323323)

[6.3 Team meetings](#_Toc514323324) 9

[7 Summary 9](#_Toc514323325)

[Annex A – SEA report template 10](#_Toc514323326)

# Introduction

## Policy statement

Providing safe, effective, high-quality patient care is the aim of all staff at Park View Group Practice. Given the complexity of primary care and the associated pressures, resulting in increased clinical and administrative workloads, it is inevitable that significant events will occur. This policy will outline the procedure for reporting significant events at Park View Group Practice and should be read in conjunction with the practice Incident Reporting Policy.

## Principles

This policy will illustrate the practice’s commitment to the safety of the patient population. By promoting a learning culture, staff are encouraged to report significant events, which will foster learning and help prevent the recurrence of similar incidents in the future.

## Status

The practice aims to design and implement policies and procedures that meet the diverse needs of our service and workforce, ensuring that none are placed at a disadvantage over others, in accordance with the Equality Act 2010. Consideration has been given to the impact this policy might have in regard to the individual protected characteristics of those to whom it applies.

This document and any procedures contained within it are non-contractual and may be modified or withdrawn at any time. For the avoidance of doubt, it does not form part of your contract of employment.

## Training and support

The practice will provide guidance and support to help those to whom it applies understand their rights and responsibilities under this policy. Additional support will be provided to managers and supervisors to enable them to deal more effectively with matters arising from this policy.

# Scope

## Who it applies to

This document applies to all employees, partners and directors of the practice. Other individuals performing functions in relation to the practice, such as agency workers, locums and contractors, are encouraged to use it.

## Why and how it applies to them

It is the responsibility of all staff to ensure that they recognise, respond to and take the necessary actions regarding significant events. Staff must operate in an open and transparent manner, acknowledging that mistakes happen and take the subsequent necessary actions to report all incidents, thereby further reducing the risk of recurrence and ensuring that a high level of patient care is delivered at all times. Furthermore, staff are required to share best practice, as significant events can arise through positive actions.

# Definition of terms[[1]](#footnote-1)

## Patient safety

The reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum. An acceptable minimum refers to the collective notions of given current knowledge, resources available and the context in which care was delivered weighed against the risk of non-treatment or other treatment.

## Patient safety incident

An event or circumstance that could have resulted, or did result, in unnecessary harm to a patient.

## Incident

An event or circumstance that could have resulted, or did result, in unnecessary harm to a patient (intentionally the same as 3.2).

## Near miss

An incident which did not reach the patient.

## Significant event

Any event thought by anyone in the team to be significant in the care of patients or the conduct of the practice.[[2]](#footnote-2)

## Significant event analysis

A process in which individual episodes (when there has been a significant occurrence, either beneficial or deleterious) are analysed in a systematic and detailed way to ascertain what can be learnt about the overall quality of care, and to indicate any changes that might lead to future improvements.2

## Care Quality Commission

The independent regulator of all health and social care services in England.[[3]](#footnote-3)

# Significant event analysis

## Rationale

Significant event analysis (SEA herein) at Park View Group Practice is used to identify both good and poor practice; however, the overall aim of the process is to enable reflection and learning, thereby enhancing the level of service offered to the patient population.

## Involving the team

SEA at Park View Group Practice involves all members of the multidisciplinary team (MDT). Staff must acknowledge that SEAs are centred on whole-team learning and are not used to direct blame.

## Aims of SEA

The aims of completing SEAs are to:[[4]](#footnote-4)

* Identify events in individual cases that have been critical, and to improve the quality of patient care from the lessons learnt
* Instigate a culture of openness and reflective learning, not individual blame or self-criticism
* Enable team-building and support following stressful episodes
* Enable the identification of good as well as suboptimal practice
* Be a useful tool for team and individual continuing professional development, identifying group and individual learning needs
* Share learning between teams within the NHS where adverse events occur at the ‘overlap’ or in shared domains of clinical responsibility (such as ‘out of hours’, discharge problems, etc.)

## What constitutes a SEA?

Clinical and non-clinical events should be reported in cases of patient harm or where there was the potential for harm to have been caused; this includes near misses and the reporting of positive outcomes, e.g. an incident was prevented as a result of effective processes/protocols.

Examples of significant events (SE) include:4

* New cancer diagnoses
* Coping with a staffing crisis
* Complaints or compliments received by the practice
* Breaches of confidentiality
* Sudden or unexpected death or the hospitalisation of a patient
* An unsent referral letter
* Prescribing errors
* Positive cervical smears
* Positive mammography
* Important message not relayed
* Suspected meningitis
* Delayed diagnosis
* Loss of care data
* Wrong treatment
* Drug interaction

## Benefits of significant event analysis

By undertaking a SEA, it will enable the practice team to:

* Reflect on the incident
* Discuss and implement preventative measures
* Enhance learning
* Demonstrate a culture of openness and transparency

## Reporting advice

All staff are permitted to raise and complete a SEA; however, to enable learning and prevent similar repeat occurrences, it is requested that staff advise the practice manager of their intention to complete a SEA. Patient and staff personal identifiable information is not required when completing a SEA; staff should refer to the individuals involved as Patient A, Doctor A, Nurse A, etc.

# Demonstrable evidence

## CQC inspections

To satisfy CQC inspectors, Park View Group Practice will have to provide evidence of the following:4

* Staff can, and are aware how to, prioritise a SE
* Evidence of information gathering
* Structured team meetings to discuss, investigate and analyse SEAs
* Outcomes are agreed, and changes agreed, implemented and monitored
* SEAs are recorded effectively
* All those involved receive a copy of the SEA report (electronically)

At the team meetings to discuss SEAs, the CQC will expect to see evidence of the following:

* A complete analysis of the SE
  + What happened and why did it happen
  + Could anything have been done differently
  + What lessons have been learned
  + What needs to change and how will this be implemented

The following are possible outcomes:

* No further action required
* MDT discuss what is deemed best practice / excellent level of care
* Training need/s identified
* There is a requirement for audit
* Immediate actions are required to prevent future events
* MDT discuss lessons learnt

The flow diagram overleaf illustrates the SE process.

# Recording significant events

## Template usage

At Park View Group Practice, all staff must use the template at Annex A to record SEAs.

## Practice lead

The lead for SEs at Park View Group Practice is Dr. K McEwan and they will be able to provide guidance to individuals should they have any queries or concerns relating to SEs.

## Team meetings

At Park View Group Practice team meetings to discuss SEs will be held in the Boardroom every last Thursday of the month and all clinical staff will be required to attend.

# Summary

Significant events are a daily occurrence across the NHS. By demonstrating a culture of accurate reporting, it will illustrate a whole-team approach to maintaining a safe and effective environment and the drive to deliver an excellent standard of patient care at Park View Group Practice.

# Annex A – SEA report template

|  |  |
| --- | --- |
| SEA reference |  |
| Date of SE |  |
| Date of SE meeting |  |
| Title of SE |  |
| Staff present at meeting |  |
| SE raised by / SEA lead |  |

|  |
| --- |
| What happened? |
| *Describe in detail what actually happened. It is pertinent to include where the incident happened, those involved (Patient X, Dr Y and Nurse Z), how it happened and the consequences of the event.* |

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| Why did it happen? |
| *What were the root causes that led to the event happening (both positive and negative)?* |

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| What could have been done differently? |
| *Consider what, if anything, could have been done differently, which would have led to a more positive outcome or experience.* |

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| What has been learned? |
| *Describe in detail lessons learned. Include information about whole-team and individual learning post-event, including reflection.* |

**Continued overleaf…**

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| What are the requirements for change? |
| *Describe in detail the agreed requirements for change and how the change will be implemented and subsequently monitored. Where applicable, hyperlink updated policies or protocols to reflect and evidence change.* |

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| What is the overall outcome? |
| *State the outcome of the SEA, which can include: no further action required, training identified, a requirement to audit, best practice identified, etc.* |

**Continued overleaf…**

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| --- |
| Outstanding actions? |
| *State any outstanding actions, who is to complete the action/s and the agreed date for completion.* |

|  |  |
| --- | --- |
| Signature of SE lead |  |
| Name |  |
| Date |  |
| Signature of practice manager |  |
| Name |  |
| Date |  |

1. [RCGP Reporting and learning from patient safety incidents in general practice](https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwjh472ujL7YAhUHAcAKHd_NBJcQFggxMAA&url=http%3A%2F%2Fwww.rcgp.org.uk%2F-%2Fmedia%2FFiles%2FCIRC%2FPatient-Safety%2FReporting-and-learning-from-patient-safety-incidents.ashx) [↑](#footnote-ref-1)
2. [NPSA Significant Event Audit Guidance for Primary Care Teams](http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=61501http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=61501) [↑](#footnote-ref-2)
3. [CQC About us](http://www.cqc.org.uk/about-us) [↑](#footnote-ref-3)
4. [CQC SEA](http://www.cqc.org.uk/guidance-providers/gps/nigels-surgery-3-significant-event-analysis-sea) [↑](#footnote-ref-4)