

# Guide to significant event audit

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Under section 2.3 of essential service 8, the new contract for NHS pharmaceutical services in England and Wales expects each community pharmacist to implement a range of risk management techniques and establish systems to ensure that patient safety is maintained and significant events are reviewed to minimise their recurrence.

## Brief history of significant event audit

Significant event audit (SEA) is not a new concept. Its origins stem from the 1939–45 war, when the US Air Force employed the concept to review why some bombing raids were more effective than others. Since the war, SEA has been used widely by the aviation industry, which views it as an excellent way of reviewing untoward incidents and maintaining passenger safety.

Within the NHS, SEA is a relatively new phenomenon. Of course, for many years health care professionals have regularly reviewed incidents and learnt from the outcomes to improve patient care, but few have done so in a systematic and structured format.

In recent times, momentum for establishing SEA has gathered pace, particularly within primary care organisations. Mike Pringle's occasional paper on significant audit to the Royal College of General Practitioners in 1995 helped establish the concept and the Department of Health's publication of "An organisation with a memory" in 2000 highlighted the need for the NHS to learn from previous mistakes. This document undoubtedly raised the profile of SEA.

The expectation for health care professionals to familiarise themselves with SEA is now greater than ever. The publication of the GP contract in 2004 highlighted its value and, to meet contractual requirements, all GP practices must review 12 significant events every three years. The National Patient Safety Agency increasingly promotes SEA audit as an invaluable risk management technique.

## What is significant event audit?

Across the NHS, various terminology is used for SEA and the concept can also be represented by other terms, such as significant untoward incidents.

Professor Pringle established a useful definition of SEA in 1995, when he defined it as "a process in which individual episodes 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 improvements".

In basic terms, SEA involves getting the members of a team together to discuss an event that has occurred. It essentially amounts

## Panel 1: Elements of the new pharmacy contract that SEA will help meet

- 2.3.4 Analysis of critical incidents by the whole pharmacy team to inform individual and organisational learning. Proactive consideration and prevention of potential risks.
- 2.3.5 Pharmacists should be competent in risk management, including the application of root cause analysis.
- 2.3.6 Pharmacists should be able to demonstrate evidence of recording, reporting, monitoring, analysing and learning from patient safety incidents.
- 2.1.5 A complaints system should be in place. The pharmacy should review complaints received and, as well as taking appropriate action on individual complaints, consider more general changes which could improve service provision.

to performing a case study/review. The usual process is that details of what has happened are presented to the wider group by the team member or members involved in the event. The group then asks questions and discusses how the situation was dealt with. Finally, actions are agreed (if necessary), a brief written summary of the event is recorded and a date is fixed for reviewing actions.

Pharmacists who have taken part in clinical audit projects will note that there is a great deal of common ground when comparing clinical audit with SEA. Both approaches involve selection of a topic or event for further examination, both involve collection and analysis of information, both involve learning and implementing changes and both aim to improve patient care. Further, both should be carried out systematically, brief reports should be written and the success of each process will depend on trust, communication and good teamwork.

Panel 1 sets out some elements of the community pharmacy contract that SEA will help meet.

## A step-by-step guide to SEA

SEA can be carried out in many ways. Traditionally, it has been suggested that health care teams should undertake monthly or quarterly meetings dedicated to reviewing significant events that have occurred. However, given the heavy workload and competing priorities of teams, many have found that the most convenient way to carry

out SEA is to set it as an agenda item within a wider team meeting and review one event per meeting. Alternately, some teams choose to hold "emergency" SEA meetings that take place immediately after a significant event has occurred. Whichever process is adopted, it is important to select a method that suits the circumstances and enables as many members of the pharmacy team as possible to be involved.

A range of techniques can be used to establish SEA within a pharmacy. One way of getting started involves the following six steps.

**Step 1: Recording** The first stage of setting up SEA involves establishing a reporting mechanism by which staff members can record details of significant events in the workplace. The reporting process should be simple and straightforward and all team members should be aware of how to record events.

Most health care teams use a simple paper form which incorporates a number of sections to be completed (eg, who completed the form, date and time of the event, details of where the event occurred, who was present, a brief factual summary of what happened and details of any action taken at the time). Some teams categorise events depending on their perceived severity and importance (eg, urgent/non-urgent).

In terms of what should be recorded, there is no definitive list of significant events. It is widely agreed that if a member of staff believes that something significant has occurred then it should be considered for review using the SEA process.

Panel 2 includes lists of significant events that are often examined by various groups of NHS professionals.

Irrespective of which events are recorded, it is advisable that documentation is completed as quickly as possible after the event while the details are fresh in the minds of those involved.

Although human nature tends to focus on problems and negative events, it is also valuable to look at why certain situations have resulted in positive outcomes.

**Step 2: Discussing the event** As mentioned previously, SEA meetings can be held in various formats. Irrespective of the format chosen, each event should start with team members involved in the event giving a brief summary of what took place. If more than one person was involved, each should be encouraged to give his or her perspective. But however the information is reported to the group, it should be done in a clear and accurate format. Once full details of the event have been given, other members present at the meeting should be in-

## Panel 2: Examples of significant events commonly reviewed by health care professionals

<b>Community pharmacists</b>	<b>GPs</b>	<b>Optometrists</b>
Prescribing errors	Sudden patient death	Equipment failure
Drug reactions not noted	Patient visit not carried out	Incorrect medicine
Needle stick injuries	Referral letter not sent	Out-of-date contact lenses
Patient unwell on premises	Prescribing error	Incorrect prescription for lenses
Wrong medicine in monitored dosage system box	Breach of confidentiality	Infection to patient
Breach of confidentiality	Computer failure	Patient falling, eg, trip hazards
Shoplifting	Non-arrival of booked ambulance	Lost documentation
Abusive patient	Misdiagnosis	Breach of confidentiality
Incorrect patient information	Patient immunised repeatedly	Letter to wrong patient, eg, similar name
Spotting interactions ( <i>positive outcome</i> )	Excellent care of terminal case ( <i>positive outcome</i> )	Opportunistic screening ( <i>positive outcome</i> )

## Panel 3: What is root cause analysis?

The National Patient Safety Agency defines root cause analysis (RCA) as “a retrospective review of a patient safety incident undertaken in order to identify what, how, and why it happened. The analysis is then used to identify areas for change, recommendations and sustainable solutions, to help minimise the recurrence of the incident type in the future. This approach is equally applicable to complaints and claims”.

Root cause analysis is a more sophisticated technique than SEA and pharmacists should consider its use for reviewing major failures.

vited to ask any questions that they think are necessary. This will help clarify precisely what has taken place.

At this point, SEA theory suggests that those involved in reviewing significant events should employ Pendleton's Rules, ie, before any judgements are made, the team should first look at positive outcomes resulting from the event. Whether or not Pendleton's Rules are adopted, the next step in the process is to discuss the event more fully, with a view to agreeing possible outcomes.

**Step 3: Agreeing outcomes** Professor Pringle has suggested classifying each event discussed into one of four outcomes — congratulations, immediate action, further work called for, or no action. It is perhaps best to clarify these with use of an example for each:

- **Congratulations** may be necessary in a case where a patient visits a pharmacy complaining of thirst and opportunistic screening indicates that the patient has diabetes.
- **Immediate action** would be required in the case of a patient complaint stating that they could overhear a medicines use review being carried out on another patient. The pharmacy would be expected to make sure immediately that the area used for MURs preserves patient confidentiality.
- **Further work called for** may be the outcome if a number of patients return monitored dosage system boxes because of errors. The errors would need to be resolved immediately, but the pharmacy may want to carry out further work (eg, a clinical audit) to see if the problem is more widespread.
- **No action** would be required if a patient had collapsed on the premises and the review of the case satisfied the pharmacy team that all necessary medical assistance had been given.

The system devised by Professor Pringle is well regarded, but pharmacy teams may wish to categorise significant events in their own way. If the outcome of a SEA meeting is that follow-up work must be done, it is vital that the team is clear who will do it, what needs to be done and what the time scales are.

**Step 4. Documenting the meeting** To make SEA more systematic, each event should be documented. Traditionally teams have kept minutes of SEA meetings, but it is increasingly popular for teams to enter information on each event onto an individual template (usually a paper form). A basic template would include: date event was reviewed; members present; brief details of the event; summary of discussions; agreed outcomes; date for review.

**Step 5: Sharing learning** Once the event has been discussed, it is crucial that the learning is shared. Some team members may not be able to attend meetings because of other commitments, part-time work, etc. Therefore, all team members should be given copies of the documentation and/or be briefed on the discussion and outcomes.

In some cases, pharmacists may think that it would be useful to inform other organisations of what has taken place, to share learning across the wider health care community. Pharmacies may feel reluctant to share “negative” events, but primary care trusts should be eager to support pharmacists who report events that may prevent similar problems for other pharmacists.

**Step 6: Revisiting previous events** It is recommended that all significant events are revisited at least annually. Certainly where events have led to immediate action or further work being carried out, it is worth revisiting them to check that actions have been implemented and changes in practice are still being observed.

### Benefits of undertaking SEA

A number of research studies have looked at the value of SEA and many have suggested that regular SEA has a beneficial impact on both clinical care and practice administration. Overall, if done well, it is likely that significant event audit will result in improved patient safety, improved team working, a more open and trusting culture among staff and the identification of staff training needs

SEA is also an interesting and challenging activity that many staff find enjoyable. To quote one practice manager identified through a survey of GP practices that undertake regular SEA: “Meetings have benefited the running of

the practice. They have initiated improvements in quality and patient care. They have improved relationships between staff and increased awareness of other people's roles”.

### Problems that may emerge from SEA

If SEA is not well managed, its introduction may lead to more problems than solutions. By its nature it can involve staff members acknowledging personal mistakes and errors. SEA must be carried out sensitively and staff need to feel supported during the process. A strong and trusted chairman is vital to making SEA work effectively. Simple problems that often occur relate to the logistical side of holding meetings and involving all team members.

Research has also shown that some SEA meetings may leave staff in an emotional state and feeling unfit for work (eg, if the sudden death of a well-known and liked patient was discussed during a daytime meeting).

### Conclusion

The new contract has brought fresh challenges to community pharmacies and many are struggling to get to grips with the various aspects of clinical governance. Community pharmacists would benefit from learning more about SEA. It is quicker and more relevant to pharmacists than clinical audit and is much easier to implement and undertake than root cause analysis (see Panel 3). SEA also lends itself to the way that pharmacists operate because the process is similar to the way in which near misses are recorded and reviewed. Further, if pharmacists adopt a sensible and appropriate approach to SEA, by looking at perhaps four to six cases each year, the work will not be onerous. Moreover, if PCTs help pharmacists review SEAs, this will have a beneficial effect on understanding why problems often occur and it is to be hoped, improve patient safety across the health care community.

### Useful resources

- Stead J, Sweeney G. Significant event audit: a focus for clinical government. Chichester: Kingsham Press; 2001.
- National Patient Safety Agency website. [www.npsa.nhs.uk](http://www.npsa.nhs.uk)
- NPSA Saferhealthcare website. [www.saferhealthcare.org.uk/ih](http://www.saferhealthcare.org.uk/ih)
- University of Exeter SEA web pages. [www.projects.ex.ac.uk/sigevent](http://www.projects.ex.ac.uk/sigevent)