SIGNIFICANT EVENT ANALYSIS (SEA)

This method brings together managers and/or practitioners to consider significant events within a case and analyse together what went well and what could have been done differently. It results in a joint action plan with recommendations for learning and development.
Significant Event Analysis or Audit has been used for many years in the NHS to analyse a significant event in a systematic and detailed way to look at what can be learnt which might lead to future improvements. Historically this method has been used to analyse events in general practice, however other areas now undertake SEA.

The seven stages of SEA are:-[1]

3.1 Awareness and prioritisation of a significant event

Staff should feel confident in their ability to identify and prioritise a significant event when it happens and encourage it to be audited. Service areas should be fully committed to the routine and regular audit of significant events.

3.2 Information gathering

Collect and collate as much factual information on the event as possible from personal records, written records and other documentation. For more complex events an in-depth analysis will be required to fully understand causal factors.

3.3 The facilitated team-based meeting

The team should appoint a facilitator who will structure the meeting, maintain basic ground rules and help with the analysis of each event. The team should meet regularly to discuss, investigate and analyse events. These meetings are often the key function in co-ordinating the SEA process and they should be held in a fair, open, honest and non-threatening atmosphere.

Agree any ground rules before the meeting starts to reinforce the educational spirit of the SEA and ensure opinions are respected and individuals are not 'blamed'.

Minutes of the meeting should be taken and action points noted.

An effective SEA should involve detailed discussion of each event, demonstration of insightful analysis, the identification of learning points and agreement on any action to be taken.

3.4 Analysis of the significant event

The analysis of a significant event can be guided by answering four questions:

1. What happened?
2. Why did it happen?
3. What has been learned?
4. What has been changed or actioned?

The possible outcomes may include:

[1] Adapted from: A Quick Guide to Conducting SEA, National Patient Safety Agency 2008

• No action required;
• Identification of excellent care;
• Identification of a learning need;
• A more detailed audit is required;
• Immediate action is required;
• A further investigation is needed;
• Sharing the learning.

3.5 Agree, implement and monitor change

Any agreed action should be implemented as soon as possible by the staff concerned and actions and progress should be monitored to ensure the necessary change has taken place.

This monitoring will be the responsibility of the Safeguarding Adults review group. To test how well the SEA process has gone, those involved in the SEA should ask themselves 'What is the chance of this event happening again?'.

3.6 Write it up

It is important to keep a comprehensive, anonymised, written record of every SEA as these may be required as evidence for future reviews. The SEA report is a written record of how effectively the significant event was analysed. In the area of adult safeguarding it may be that numerous similar SEA's or clusters may result in a much more thorough and detailed review such as RCA.

3.7 Report, share & review

Reporting when things go wrong is essential in all aspects of health & social care. There are various systems in place across health & social care which make it easy to formally report incidents when they come to light. This includes reporting all incidents which meet the organisations incident reporting criteria where safety has, or could have been, compromised.

Where a mechanism exists, agencies should also share knowledge of important significant events within their own agencies and wider so that others may learn from these. This can be done internally or by posting information on the SAB website.

It is not necessary to involve the adult at risk in the SEA, however should the findings result in the need for further review or investigation, they may need to be involved at a later stage.

To download the full guidance on SEA go to www.npsa.nhs.nrls/gp

Once an SEA has been completed the report and results should be presented back to the Safeguarding Adults review group, highlighting any lessons learnt and practice changed as a result of the audit.