

# Analysing a Significant Event

Results from peer review

# Background

- Environment of uncertainty in general practice
- SEA – a useful proxy for managing risk
- Aim is to ensure reflective learning takes place in assessing the risk of a subsequent similar event happening

# Outline of problem

- Submitted evidence of analysed significant events showed insight into the cause of some events had been missed
- Such an event recurring was therefore possibly more likely

# Key measures for improvement

- 20 trained peer assessors
- Provide formative feedback on submitted significant event analyses
- Submitted by principals in general practice

# Proforma with 4 questions

- What happened?
- Why did it happen?
- What have you learned?
- What have you changed?

# PEER REVIEW SIGNIFICANT EVENT ANALYSIS

## INSTRUCTIONS FOR ASSESSORS

Please use the marking schedule to give your opinion on the doctor's significant event project. It is crucial that the complete project is read before marking begins.

The criteria to be used for marking are in bold print. The statements in less bold print should act as a guide when making your judgement.

This will result in four criteria to be marked – a "Pass" project will require all four criteria to be present.

Please comment at any stage of the process but specifically if the doctor's audit project is not satisfactory.

PROJECT TITLE:

PROJECT NUMBER:

ASSESSOR:

## PEER REVIEW SIGNIFICANT EVENT ANALYSIS

Project no .....

1. <u>What happened?</u>	<ul style="list-style-type: none"><li>• Has personal impact</li><li>• Important to individual or organisation</li><li>• Causes reflection</li></ul>	<input type="checkbox"/>
2. <u>Why did it happen?</u>	<ul style="list-style-type: none"><li>• Clear reason sought</li></ul>	<input type="checkbox"/>
3. <u>Was insight demonstrated?</u>	<ul style="list-style-type: none"><li>• Aware of previous suboptimal care</li><li>• Decision-making process altered</li><li>• Assessment of "risk" demonstrated</li><li>• Level of personal responsibility linked to circumstances</li></ul>	<input type="checkbox"/>
4. <u>Was change implemented?</u>	<ul style="list-style-type: none"><li>• Yes - describes implementation of relevant change</li><li>• No - risk of similar significant event unlikely</li><li>• No. Unable to influence change but suggestions for change given</li></ul>	<input type="checkbox"/>

Satisfactory analysis of significant event

Yes

No

Comments for feedback (continue overleaf)

Assessor signature .....

Date .....

# Data gathered (2001-2004)

- 662 submitted SEAs by 365 GP principals
- 75 (11%) judged to be analysed inadequately
- 164 (25%) judged a satisfactory analysis but could be enhanced by some additional reflection
- 422 (64%) judged satisfactory

# Strategies for change

- Provide a structured approach to analysing and peer assessing a significant event
- Provide feedback to encourage a deeper understanding on the possible cause of the event and action required
- Focus group analysis involving GPs submitting SEAs showed that trained assessors in the process gave greater confidence in and added value to the process

# A way forward

- SEA is one of five core categories in the appraisal process of all GP principals in Scotland
- SEAs are embedded in the new contract for all GPs in the United Kingdom
- A structured approach ensuring a satisfactory analysis of a significant event may help GPs prepare their evidence on risk management for revalidation