

## Significant Event Analysis Guideline

**IMPORTANT: To claim PDP credit for this activity, please submit the SEA PDP Credit Claim Form only – see page 8. Do not submit details of the event to ACRRM.**

Significant event analysis (SEA) is a quality improvement and learning tool used to reflect on patient safety incidents (or near misses) and identify ways in which systems can be improved to enhance future patient care.

According to the Medical Board of Australia's Good medical practice: a code of conduct for doctors in Australia: Good medical practice in relation to risk management involves:

1. Being aware of the importance of the principles of open disclosure and a non-punitive approach to incident management.
2. Participating in systems of quality assurance and improvement.
3. Participating in systems for surveillance and monitoring of adverse events and 'near misses', including reporting such events.
4. If you have management responsibilities, making sure that systems are in place for raising concerns about risks to patients.
5. Working in your practice and within systems to reduce error and improve patient safety and supporting colleagues who raise concerns about patient safety.
6. Taking all reasonable steps to address the issue if you have reason to think that patient safety may be compromised.

This is a simple template for significant event analysis, to outline what happened, where it happened, potential impacts and what was learned. A risk matrix to identify risk level is also included.

This activity should examine underlying systems and deal with weaknesses in those systems to improve patient care. It is not intended to direct inappropriate blame to individuals.

## Next steps:

1. The nominated individual or team collects information about the event, including review of clinical records and policy/ guidelines
2. Protect patient confidentiality and anonymise identifiable information prior to discussion
3. Involve a wide range of staff in the review where relevant to ensure a variety of perspectives
4. Organise the SEA meeting and use the template questions to generate a discussion and report
5. Agree, prioritise and action changes where appropriate
6. Put process in place to evaluate changes to monitor progress and revisit goals if necessary
7. Claim PDP credit by using the SEA PDP Credit Claim Form on last page

## What happened?

Describe what actually happened in detail. Include the date/s and order of events, how it occurred, who was involved and the location of the event. What was the impact or potential impact on the patient, team, organization and others? Use the Seriousness Assessment Matrix and SAM Guide to assess the level of risk associated with the event – see appendix 1.

## Why did it happen?

What are the factors contributing to the event? Think about the people, tasks and environment and the interactions between them. Consider, for instance, the professionalism of the team, the lack of a system or breakdown of a system, lack of knowledge or skills, environmental factors or the complexity and uncertainty associated with the event. Try to look for root causes, rather than superficial explanations.

### **What can be learned – how could things have been different?**

Reflection and learning should take place on several levels including – individual, team and organisational. Consider training needs, reinforcement/ change in systems, processes or policies, changes in team roles and communication, etc.

### **What needs to change and what is the action plan?**

Outline the agreed action/s and how they can be implemented. For example, identify learning needs, further information required, immediate actions to rectify problems, recommend changes to protocols, improve communication etc.

### **How and when will you monitor the success of any agreed changes?**

**What does improvement look like and who is responsible for measuring progress and reporting back?**

## Seriousness Assessment Matrix

|                                |                           | Seriousness of event  |       |          |       |              | Risk rating | Risk classification |
|--------------------------------|---------------------------|---|-------|----------|-------|--------------|-------------|---------------------|
|                                |                           | INSIGNIFICANT   | MINOR | MODERATE | MAJOR | CATASTROPHIC |             |                     |
| Likelihood of event recurrence | FREQUENT (almost certain) | 2   | 2     | 3        | 4     | 4            | 1           | Low risk            |
|                                | PROBABLE (likely)         | 2   | 2     | 3        | 4     | 4            | 2           | Moderate risk       |
|                                | OCCASIONAL (possible)     | 1   | 2     | 3        | 3     | 4            | 3           | High risk           |
|                                | UNCOMMON (unlikely)       | 1   | 1     | 2        | 3     | 4            | 4           | Extreme risk        |
|                                | REMOTE (rare)             | 1   | 1     | 2        | 2     | 4            |             |                     |
| PROBABILITY CATEGORIES         |                           | DEFINITION  |       |          |       |              |             |                     |
| Frequent (almost certain)      |                           | Expected to occur again, either immediately or within a short period (likely to occur most weeks or months) |       |          |       |              |             |                     |
| Probable (likely)              |                           | Will probably occur in most circumstances (several times per year)  |       |          |       |              |             |                     |
| Occasional (possible)          |                           | Probably will recur, might occur (may happen every one to two years)  |       |          |       |              |             |                     |
| Uncommon (unlikely)            |                           | Possibly will recur (could occur in two to five years)  |       |          |       |              |             |                     |
| Remote (rare)                  |                           | Unlikely to recur – may occur only in exceptional circumstances (may happen every five to 30 years)         |       |          |       |              |             |                     |

## Seriousness Assessment Matrix

| CATASTROPHIC   | MAJOR  | MODERATE  | MINOR   | INSIGNIFICANT   |
|--|--|---|---|---|
| <b>Consumer:</b> issues regarding SAC1 events <sup>[1]</sup> , long-term damage, grossly sub-standard care or involving a death that requires investigation.   | <b>Consumer:</b> significant issues of standards, quality of care, or denial of rights. Feedback/complaints with clear quality assurance or risk management implications or issues causing lasting detriment that require investigation. Where a consumer has required surgical intervention or has suffered disfigurement or major permanent loss of function as a result of the event. | <b>Consumer:</b> issues that may require investigation. Legitimate consumer concern, especially about communication or practice management, but not causing lasting major detriment. The consumer may have a permanent lessening of bodily functioning or increased length of stay or required an additional operation or procedure as a result of the event. | <b>Consumer:</b> no impact on or risk to the provision of health care or the organisation. Feedback/complaint could be easily resolved at the frontline. Significant lapses in customer service (where no injury sustained). Consumer may have required a temporary increased level of care due to the event. | <b>Consumer:</b> trivial, vexatious or misconceived complaint. No injury to consumer or impact on their length of stay or level of care required. |
| <b>Visitors:</b> death of visitor or hospitalisation of three or more visitors.  | <b>Visitors:</b> hospitalisation of one or two visitors.   | <b>Visitors:</b> medical expenses incurred or treatment of one or two visitors, but not requiring hospitalisation.  | <b>Visitors:</b> evaluation and treatment with negligible expenses.   | <b>Visitors:</b> no treatment required, or treatment refused.   |
| <b>Reputation:</b> Highly probable legal action and likely to result in Ministerial censure. Maximum multiple high-level exposure. Ministerial censure. Loss of credibility and public/key stakeholder support.    | <b>Reputation:</b> threat of legal action and Ministerial notification. Headline profile. Repeated exposure. At fault or unresolved complexities impacting public or key groups. Ministerial involvement.  | <b>Reputation:</b> potential for legal action. Repeated non-headline exposure. Slow resolution. Ministerial enquiry/briefing.   | <b>Reputation:</b> non-headline exposure. Clear fault. Settled quickly by health service response. Negligible impact.   | <b>Reputation:</b> non-headline exposure. Not at fault. Settled quickly. No impact.   |
| <b>Professional conduct:</b> serious and willful breach. Criminal negligence or act. Litigation or prosecution with significant penalty. Possible grounds for dismissal. Ministerial censure. Criminal misconduct. | <b>Professional conduct:</b> deliberate breach or gross negligence. Significant harm. Formal investigation. Disciplinary action. Ministerial involvement. Serious misconduct.  | <b>Professional conduct:</b> negligent breach. Lack of good faith evident. Performance review required. Material harm caused. Misconduct established.   | <b>Professional conduct:</b> breach resulting in minor harm and investigation. Evidence of good faith arguable.   | <b>Professional conduct:</b> innocent procedural breach. Evidence of good faith by degree of care/diligence. Little impact.                       |
| <b>Services:</b> complete loss of service or output, serious threat to customer service relationships, or permanent harm to reputation of the service.   | <b>Services:</b> complete loss of service or output, serious threat to customer service relationships, or permanent harm to reputation of the service.   | <b>Services:</b> disruption to users due to agency problems. Potential to impact on service provision/delivery.   | <b>Services:</b> reduced efficiency or disruption to agency working.  | <b>Services:</b> no loss of service.  |

| <b>Financial:</b> critical financial loss  | <b>Financial:</b> major financial loss   | <b>Financial:</b> moderate financial loss   | <b>Financial:</b> minor financial loss  | <b>Financial:</b> no, or minor, financial loss   |
|--|--|---|---|--|
| <b>Environmental:</b> extensive very long term or permanent, significant, unacceptable damage to, or contamination of significant resource or area of environment. Very long term or permanent denial of access or exposure. | <b>Environmental:</b> high level but recoverable, unacceptable damage or contamination of significant resource or area of environment. Significant intervention, permanent cessation of harmful activity. Long term suspended access, presence or use of resource. | <b>Environmental:</b> moderate impact. Medium level intervention indicated to bring about recovery. Short to medium term restriction of access or exposure. | <b>Environmental:</b> low level impact. Quick recovery with minimal intervention. Minimal disruption to access or exposure. | <b>Environmental:</b> negligible impact. Spontaneous recovery by natural processes. No disruption to access or exposure. |

## SEA PDP Credit Claim Form

**Please use this page only as your evidence of activity to claim PDP hours for a Significant Event Analysis under the Outcome measurement category. Do not submit the rest of this document to ACRRM.**

|   |  |
|---|--|
| Member name   |  |
| Member number   |  |
| Date of SEA meeting   |  |
| Number of attendees   |  |
| Hours spent on this activity<br>(including research and reflection<br>time) |  |