**Generic Template for Significant Event Analysis (SEA):**

Based on the principles of Good Medical Practice and Revalidation.

**Reflection:** *Thinking about something to learn from it*

**Insight:** *The degree to which both topic and outcome of*

*reflection are considered appropriate by one’s peers*

In the context of professional appraisal, reflection with insight is synonymous with the term *reflection*. It is demonstrated when the doctor appropriately addresses areas for improvement across the four domains of Good Medical Practice relevant to their professional roles.

**Significant Event:** *Any suitable topic for reflection that might benefit from a formal, structured approach either because of complexity, potential risk or the need to involve others in the analysis.*

An SEA is usually undertaken to prevent recurrence of an adverse event. Positive events are often “near-misses” and an SEA can serve to celebrate good practice while alerting colleagues to potential pitfalls.

In practice, SEAs often contain thorough case descriptions but little else. It is worth remembering that the purpose of the description section is to enable others to reflect on the case in question, and not an end in itself. Once the description is complete, the subsequent reflective analysis should not be considered complete until the causation of the event in question is fully understood.

**Essential Elements in a Significant Event Analysis:**

***Cycle 1***

1. **Title & Context:**

Descriptive title of event, author of document, date of event, date of meeting, who were present. Set future date for Cycle 2 to assess impact of actions agreed in section 6.

|  |
| --- |
|  |

**2. Facts of Event:**

Establish facts. The purpose of this section is to enable colleagues to understand the case sufficiently to participate fully in the analysis. Keep it simple and easy to read

|  |
| --- |
|  |

**3. Impact of Event:**

What was the (potential) impact on those involved (patient, carer, family, GP, practice)?

|  |
| --- |
|  |

**4. Analysis:**

By the end of this section, we should know what caused the event, which is likely to be multifactorial. Identify the key moments, what was done or not done, that influenced the outcome, and what factors contributed. To further enhance your understanding of why your event happened, you may want to apply a more structured systems-based approach to your analysis using some [basic 'human factors' principles](http://www.nes.scot.nhs.uk/shine/) to explore the range of human-system interactions which contributed to your event.

|  |
| --- |
|  |

**5. Lessons learned:**

Summarise what you have learned from analysing this event.

|  |
| --- |
|  |

**6.** **Action Points:**

Summarise what action has been taken to date, and is planned going forward, to reinforce good practice and minimise the chance of any future adverse event. Consider the four areas of [Good Medical Practice](http://www.gmc-uk.org/guidance/good_medical_practice.asp), i.e. knowledge, skills and performance; safety and quality; communication, partnership and teamwork; and maintaining trust. Ensure actions are SMART and assigned.

|  |
| --- |
|  |

***Cycle 2***

**7. Reanalysis and review after implementation:**

To perform their role as tools for improving practice, SEAs should be returned to at a later date and form part of a two-cycle reflective analysis that assesses the impact of the actions taken (section 6). Were they implemented? Were there barriers to their implementation? Is there evidence of an improvement that should be sustained? Are any further actions indicated?

|  |
| --- |
|  |

**8.** **Community of practice :**

Your reflection on the significant event or process of undertaking this SEA could have implications for the wider professional community. Are there any solutions, learning or issues that would benefit from being shared more widely? e.g. could another practice benefit from a solution you devised in the course of this SEA or is there an issue that you could benefit from discussing with colleagues at interfacing services?

|  |
| --- |
|  |