# Tool 12 – Significant-event audit

## Why you should use this tool

Significant-event auditing is a structured approach to reviewing events that have occurred in your PCT, practice or care agency. This may already be incorporated into your PCT/practice/care agency processes and procedures.

## When to use this tool

The table overleaf enables you to record your learning needs resulting from a significant event. This may be an unexpected adverse clinical event, such as when a patient delayed seeking help from a GP or nurse as they were self caring for too long. Such events might be in any area of work: prevention, acute care, long-term conditions, organisation or management. When a culture of supporting self care is established in your PCT, practice or care agency and a serious adverse event has occurred, you will need to use this tool to help you understand how to avoid a similar event occurring in the future.

## What to do

Record significant events where someone experienced an adverse event or had a near miss.

- Describe the incident.
- Recount the affect on all of the participants involved.
- Deduce the reasons for the event arising through discussion and a review of records, procedures etc.
- Decide how you or others might have behaved differently and describe your options for how procedures might be changed to reduce or prevent recurrences.
- Agree any changes that are needed, how they will be implemented, who will be responsible for what and key timelines.
- Re-audit later to see if the changes have worked, give feedback to the team and acknowledge good care.

Discuss the completed significant-event audit at a meeting with GPs, nurses or local pharmacists – the primary care team – or within a special interest group. Determine what lessons can be learned, what areas require further work on your part, how care can be improved, who is responsible for the action plan and when actions need to be implemented.

**Time:** at least an hour for the initial discussion of the significant event, followed by as much time as is needed to gather information about the factors leading up to the event, consider possible changes, recruit support for the action plan and subsequent change, and review progress leading to re-audit.

## How it works

Significant-event auditing, critical-incident analysis and adverse-event monitoring are all forms of risk management that can improve the quality of self care support provided within a PCT, practice or care agency. Significant events can give an understanding of the care that individual practitioners or the practice team deliver. While all significant events have the capacity to be identified as areas for improvement, most can also demonstrate good or appropriate care.

Adverse events are where something clearly has gone wrong and the PCT, practice or care agency needs to establish what happened, what was preventable and how to respond. Adverse events might include a patient's complaint, an allergic reaction to a drug bought over the counter as a form of self care, or a prescribing error that came about as home remedies clashed with a patient's prescribed drug(s).

## What to do next

Maintain the progress needed to undertake the activities in the action plan, then re-audit.

For more information on this tool, please click on **Tool 12**.

Working in Partnership Programme

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self care ...because health matters

# Recording your learning needs from significant-event discussion

| Patient reference, sex, age | Event | Learning needs | Actions |
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