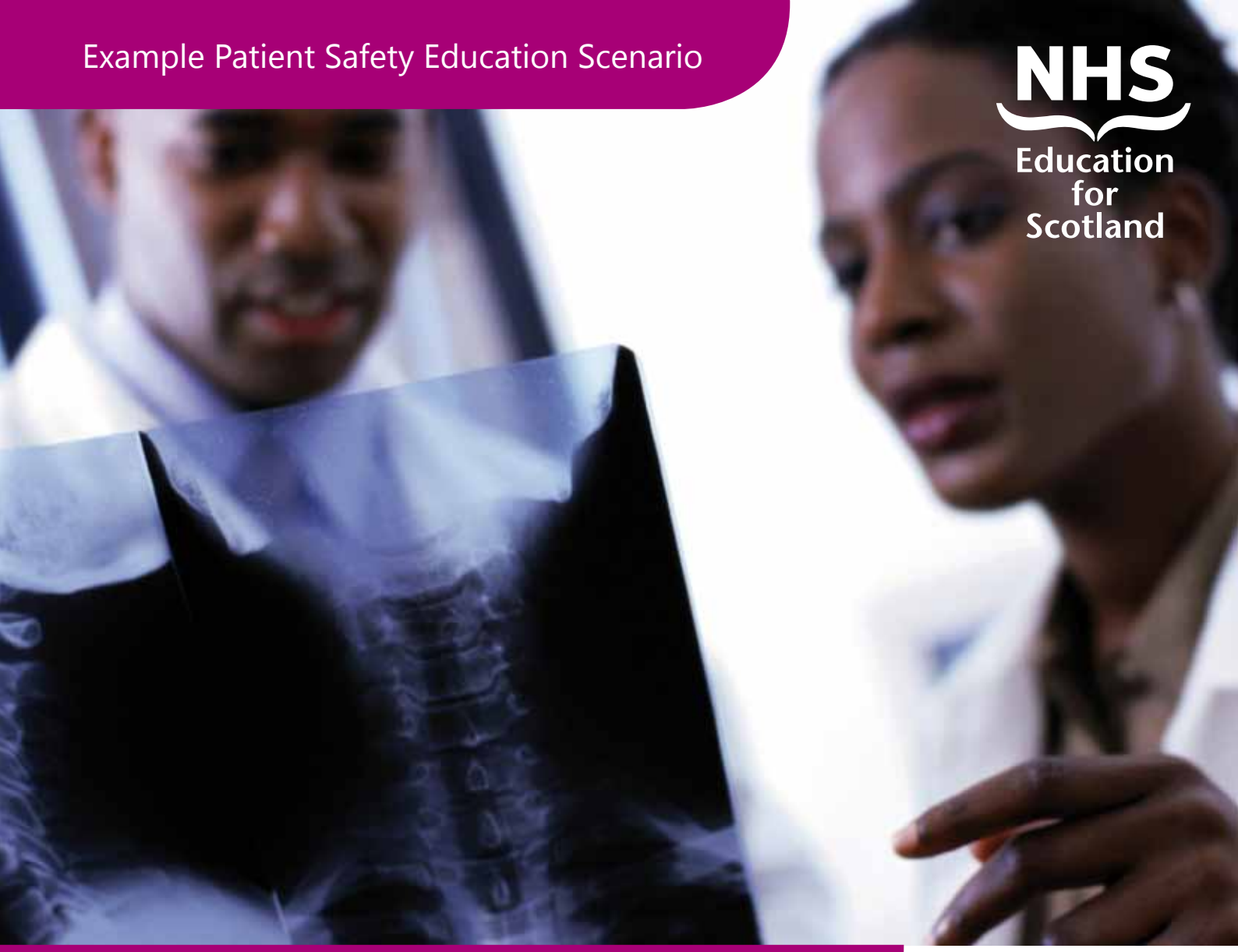
Example Patient Safety Education Scenario

NHS Education for Scotland



Improving Significant Event Analysis using feedback from trained peer groups

Importance of Significant Event Analysis (SEA), improving Patient Safety

Significant Event Analysis (SEA) is now well-established as a key approach to learning from patient safety incidents. The technique originated in general medical practice in the early 1990s as a method of reflective learning, and has now spread to a variety of healthcare settings and professions in the UK and internationally.

The SEA process involves healthcare teams meeting to discuss and structurally analyse incidents where patients are unintentionally harmed - or could have been - as a result of the care they experienced. Teams are also encouraged to highlight events involving excellent clinical practice so others can learn from them.

In the past decade, NES has published a series of research articles[1] that have made a major contribution to the evidence-base underpinning the development, application and evaluation of SEA as a team-based learning and improvement technique in the NHS.

Evidence of participation in SEA by teams and individuals is now necessary to satisfy the governance requirements of a number of external bodies e.g. quality accreditation, educational supervision, specialist training, appraisal and continuing professional development.

[1]Bowie P., Pope L. and Lough M., *A review of the current evidence base for significant event analysis.* Journal of Evaluation in Clinical Practice 2008; 14: 520 - 536

SEA Feedback from Trained Peers

NES research and evaluation work has shown wide variations in the standard of SEAs undertaken by frontline healthcare teams. The direct implication is that there are many missed opportunities to learn from and improve the safety of patient care.

As a consequence, NES developed a robust educational model to enable clinicians, managers and healthcare teams to submit SEA reports for feedback from trained peer groups. This voluntary service is available for GPs, General Dental Practitioners and Foundation Year Doctors in the west of Scotland as part of arrangements for CPD and specialist training. Similarly, the model is also available on a national basis to Pharmacists and General Practice Managers. Community Physiotherapists in NHS Greater Glasgow and Clyde have also participated in a pilot project.

> *. . . the SEA, where you look at what conclusions have been drawn and you go whoa, whoa – you just really missed the point here.*
>
> GP Peer Reviewer (Focus Group)

> *SEA is an excellent form of CPD activity. A formal report of this with external feedback is appropriate evidence for my portfolio...Physiotherapy staff should be exposed to this...*
>
> Community Physiotherapist, Glasgow

Background Theory: Peer Review

The concept of 'peer review' is well established in healthcare. However, the novel aspect of this model is that it appears to be the only one reported in the literature that utilises peers who are specifically trained to review and provide developmental feedback on SEA activity. Different peer groups also provide feedback on other safety and improvement-related activities such as videoed-consultations and clinical audit.

The underlying principles of the NES model are based on an adaptation of cognitive continuum theory. This framework aids understanding of the thinking used in performing a range of tasks. The aim is to improve the quality of reflection on particular tasks. How this is done is described in one of six 'modes of practice' ranging from the highly structured scientific experiment (mode 1) to intuitive judgements (mode 6). Peer review sits between modes 4 (system-aided judgement) and 5 (peer-aided judgement) and is designed to minimise the probability of a mode 6 judgement (self-assessment) leading to invalid conclusions on decisions made.

How is the education delivered, and links to safer care?

The model works as follows: Individual clinicians and managers submit their SEA reports to NES. The reports are screened for confidentaility issues before being sent to two members of a trained peer group. The report is assessed independently by each peer, aided by a validated assessment instrument. Developmental, constructive and confidential comments on the standard of the SEA are returned to a peer review co-ordinator who then collates the feedback and passes on a written report to the submitting individual. Typically the feedback confirms the SEA to be of a good standard or highlights potential areas for improvement.

> *"I found the whole process very rewarding and I am glad I took part. External peer review is very useful as it is completely unbiased with no personal feelings towards the person doing the work."*
>
> Practice Manager, Glasgow

> *"Many thanks for your constructive feedback...I will review the report and make appropriate changes. Your input and that of the peer reviewers is very welcome."*
>
> General Practitioner, Ayr

What is good about this form of learning, contributing to improving healthcare?

For patients and the public: Reassurance that healthcare teams take patient safety seriously and are learning from systems failures and clinical errors. Further independent review of SEA acts as a 'double-check' on standards and may be useful for making judgements where SEAs attract public funding.

For healthcare professionals and teams: Facilitates the identification of learning needs and opportunities for rapid improvement in patient safety with external review acting as an independent feedback mechanism and offering additional developmental insights by colleagues trained in the process.

For NHS Board Leaders and Educational Specialists: Validates and enhances the purported value and role of SEA in education, learning and patient safety.

Impact on Patient Safety

- ***SEA contributes to organisational learning and helps build a safety culture:*** Embedding SEA as part of accreditation, appraisal and educational initiatives has enabled healthcare teams to learn from patient safety incidents, which previously might not have been prioritised or dealt with adequately.
- ***Independent review of SEA is a key improvement mechanism:*** Feedback on SEA from trained peer colleagues has provided important input into further system changes and improvements which were necessary to minimise the risk of future hazards and harm to patients.
- ***Greater understanding and evidence of learning and improvement:*** Research on submitted SEA reports has led to a more informed understanding of: what goes wrong in different healthcare settings; why safety incidents may occur; the range of individual and healthcare team learning needs identified; the types of system changes which are necessary; and insights into the sustainability of improvements.

> *"It's not just the public; it is anyone outside the practice. It is just a little bit too cosy to just mention your errors to one person and expect that to necessarily promote things forward... I can see for the general public you know, if you want things to have any kind of rigour then you want outside comments."*
>
> General Practitioner (Focus Group)

> *"GP Appraisers might not be quite as honest and quite as frank as someone completely independent."*
>
> General Practitioner (Focus Group)

> *"Thank you for arranging this peer review which is always thought provoking. The feedback always encourages me to try a bit harder."*
>
> General Practitioner, Glasgow

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Published by NES Patient Safety Multi-disciplinary Group, March 2011
http://www.nes.scot.nhs.uk/initiatives/patient-safety