**Prescribing Tip For Information**

***PrescQIPP CQC - Significant Event Analysis***

Significant event analysis (SEA) can be used to show quality improvement in the 'safety' key question of a CQC inspection: *Key line of enquiry*[*: Are lessons learned and improvements made when things go wrong?*](https://www.cqc.org.uk/node/2565)

SEA uses case analysis to encourage the whole healthcare team involved in a case or incident to have a supportive discussion. The aim is to use this as a process to allow reflection and learning from the incident and so improve care.

Examples of significant events can be very wide-ranging and can reflect good as well as poor practice:

**new cancer diagnoses complaints or compliments received**

**breaches of confidentiality prescribing error**

SEA should act as a learning process for the whole practice whilst encouraging a culture of openness and reflective learning. The process can be a useful tool for team and individual continuing professional development, identifying learning needs whilst also improving the quality of patient care from lessons learnt.

**CQC inspections will look for the impact and learning that has resulted from the SEA and see evidence of the following:**

1. All staff should be aware of and be able to prioritise a significant event.
2. There should be evidence of information gathering, including factual information on the event such as personal testimonies, written records and other health care documentation. For more complex events, more in-depth analysis will be required.
3. A facilitated team-based meeting should have occurred to discuss, investigate and analyse events. There should be evidence of regular meetings for the purpose of SEAs.
4. Agree, implement and monitor change. There are no fixed end-points; outcomes should be revisited and the implementation and success of any agreed changes monitored at pre-set intervals.
5. Written records and all the processes of the SEAs should be written up to form a report. This should record how effectively the event was analysed.
6. Report, share, review - the SEA should be shared with all members involved in the significant event.

Examples of good practice and case studies where improvement was needed can be found on the CQC website:

[CQC - Significant Event Analysis](https://www.cqc.org.uk/guidance-providers/gps/inadequate-example-significant-event-analysis-sea)