SIGNIFICANT EVENT AUDIT HISTORY

GO

1940s
PIONEERS

First evidence of SEA being used in healthcare emerges from University of Pittsburgh's School of Dentistry.

1982 - Confidential Enquiries into Peri-operative Deaths (CEPOD) adopt the SEA model for reviewing deaths.

1980s/1990s - Isolated examples of general practice using SEA methodology to review safety incidents in UK.

1995
KEY MOMENT

The Royal College of General Practitioners publish Professor Mike Pringle's Occasional Paper on SEA. This moves SEA from the margins to centre stage.

2003 - GP contract formalises the importance of SEA by including it within the Quality and Outcomes Framework. Initially all practices have to report 12 events every 3 years.

2008
BEST PRACTICE

The National Patient Safety Agency publish *Significant Event Audit: Guidance for Primary Care Teams.* This document is the first of its kind to identify best practice for those conducing SEA.

2012 - GMC revalidation guidance specifies that doctors must reflect on significant events with their appraiser.

Today - The Care Quality Commission routinely ask to see SEA documentation. They use this information and evidence to evaluate patient safety in general practice.