Significant event analysis: write-up template

Work through the seven stages below for a single event. Most portfolio SEAs are strong on stages 1 to 5 and weak on 6 and 7, which is exactly where assessors look hardest. Keep it concise and write stages 5 to 7 in the first person.

1 What happened

The event, factually. Date, setting, your role, what occurred. Anonymise fully. No interpretation yet.

2 Why it happened

Contributory factors. Look past the immediate cause to the system: task, individual, team, conditions, organisation.

3 The impact

On the patient, the team and you. Be honest about actual and potential harm, including a near miss.

4 What went well

The defences and catches that prevented worse. Naming these shows which safeguards to protect.

5 What you learned

Your genuine reflection. What you now understand that you did not before, and what it means for your practice.

6 What changed — WHERE MARKS ARE WON

The specific action: protocol amended, checklist added, rota changed. Named, dated, attributable. Not 'be more careful'.

7 How you know it held — THE DIFFERENTIATOR

The evidence it worked and stuck: re-audit, follow-up at M&M, incident count since, team feedback. This closes the loop.

Worked example: a missed time-critical dose

A short, anonymised example showing the seven stages applied to one event. Yours can be briefer; what matters is that stages 6 and 7 are specific and evidenced.

1. What happened
An inpatient with Parkinson's disease missed a 02:00 dose of their time-critical medication on a busy ward. The omission was identified at the morning round.

2. Why it happened
The dose fell outside standard drug rounds; it was not flagged as time-critical on the chart; agency staff were covering; the ward had no alert for off-round timings. Several conditions aligned.

3. The impact
Transient worsening of rigidity and distress for the patient. No lasting harm. A near miss in terms of aspiration risk.

4. What went well
The morning team recognised the omission promptly, gave the dose, and escalated to the consultant and ward manager the same day.

5. What I learned
Time-critical medications fail at the system level, not through one person. Charts and rounds did not protect an off-round timing, and agency cover increased the risk.

6. What changed
We added a time-critical medication flag to the e-prescribing template and a check at every handover. Agreed with pharmacy and the directorate governance lead in March 2026.

7. How I know it held
At the following quarter's M&M, two months on, no further missed time-critical doses had been reported on the ward. Re-audit planned at six months.

GMC four-domain mapping checklist

Tick the domains your write-up evidences. A strong SEA usually touches all four without forcing it.

- ☐ **DOMAIN 1** **Knowledge, skills and performance**
  Clinical reasoning in the case and the learning carried into future practice.
- ☐ **DOMAIN 2** **Safety and quality (core)**
  Recognising risk, acting on incident review, improving the system.
- ☐ **DOMAIN 3** **Communication, partnership and teamwork**
  Team discussion, MDT review, any duty of candour conversation.
- ☐ **DOMAIN 4** **Maintaining trust**
  Honesty about what went wrong and taking responsibility for improvement.