Significant Event Audit Case Example: A post-operative complication

Section A: Case example on the six stages on a significant event audit

A Significant Event Audit (SEA) is a quality improvement technique. It is a retrospective audit, which looks at one case in detail from beginning to end, to either increase the likelihood of repeating outcomes that went well or to decrease the likelihood of repeating outcomes that went badly. SEAs may result in the further development of guidelines, protocols or checklists and may result in the need for additional clinical audits (process, structure or outcome). SEAs are conducted by bringing your team and the relevant case notes together to discuss the event. The event must be discussed without any blame – allowing team members to provide honest and constructive feedback on how they contributed to the care process. A SEA is completed in six stages. The following points will take you through the steps that this practice took to put a SEA into practice.

1. Identify the significant event

Create a brief description of the event, context and outcome to be discussed in the meeting.

A patient developed an abscess on its surgical wound.

2. Collect all the relevant information

Gather all relevant information, such as case files and staff accounts etc., which contribute to the case.

The case was reported and information was gathered from the patient's clinical notes, and the team involved.

3. The meeting and analysis

In a team discussion regarding the event, analyse the event and its causes to suggest where changes can be made. Indicate changes that could aid in achieving the desired outcome. It is important to ensure this meeting provides an environment where all staff members are encouraged to speak freely and honestly.

A meeting was held with all team members to discuss the events that may have caused the post-operative complication. These factors were discussed and organised into System, Human, Patient, Owner and other factors.

4. Decide what changes need to be made

Confirm which changes should be made, and make a prediction on the effect this will have. It may be that no change is required or there is only a need to disseminate the findings. Where changes are made, they could be in the form of checklists, guidelines or protocols. Following the meeting, a final report detailing the key points raised in stages 1-4 should be written.

Further additions were required on the checklist, to remind the team to discuss antibiotic requirements for patients.

5. Implement the changes

Develop an action plan. What needs to be done by whom, when and how? Ensure the whole practice team is aware of the changes and what role they play in implementing them. Monitor the changes once implemented and set a time to review them. The length of time required for monitoring will be dependent on the event.

The change was implemented.

6. Review the changes

The team should sit down together to review the changes and discuss what went well and what didn't. You could also share what you have found with clients and the profession. Further audits may be required to monitor the change.

Further audits will be completed as required.

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Section B: A significant event audit after a post-operative complication

Title:	Significant event audit for a post-operative complication
Date of significant event:	22/02/2019
Date of meeting:	26/02/2019
Meeting lead:	Veterinary team
Team members present	The whole practice team

What happened?

A patient developed pyrexia after an enucleation procedure. Three days post-surgery, an abscess formed on the surgical wound. It required surgical intervention to drain and flush the abscess, along with antibiotic therapy.

At the SEA meeting we found out the following:

The requirement for antibiotics was not discussed between the team during surgery, despite the patient having ongoing ocular infections.

Why did it happen?

System factors:	· No reminder for the team to discuss antibiotic requirement during the procedure.
Human factors:	· The veterinary team failed to identify the potential need for antibiotics at the time of procedure.
Patient factors:	· The patient had a long history of eye infections and subclinical conjunctivitis.
Communication factors:	· No reminder for the team to discuss antibiotic requirement during the procedure.

What has been learned?

There needed to be an assessment of each case on an individual basis. This included the requirement for antibiotics, which may differ based on the patient's history.

What has been changed?

CPD/training required:	· None required.
New or updated protocols/checklists/guidelines:	· Checklist change to include pre/peri and post-operative medications.
Further audit required?	· As required.