Case Example: An organisational wide approach to QI at PDSA

Name of initiative: Reporting of clinical incidents
Initiative start date: January 2019
Submitted by: Steve Howard BVMS MRCVS DMS, Head of Clinical Services

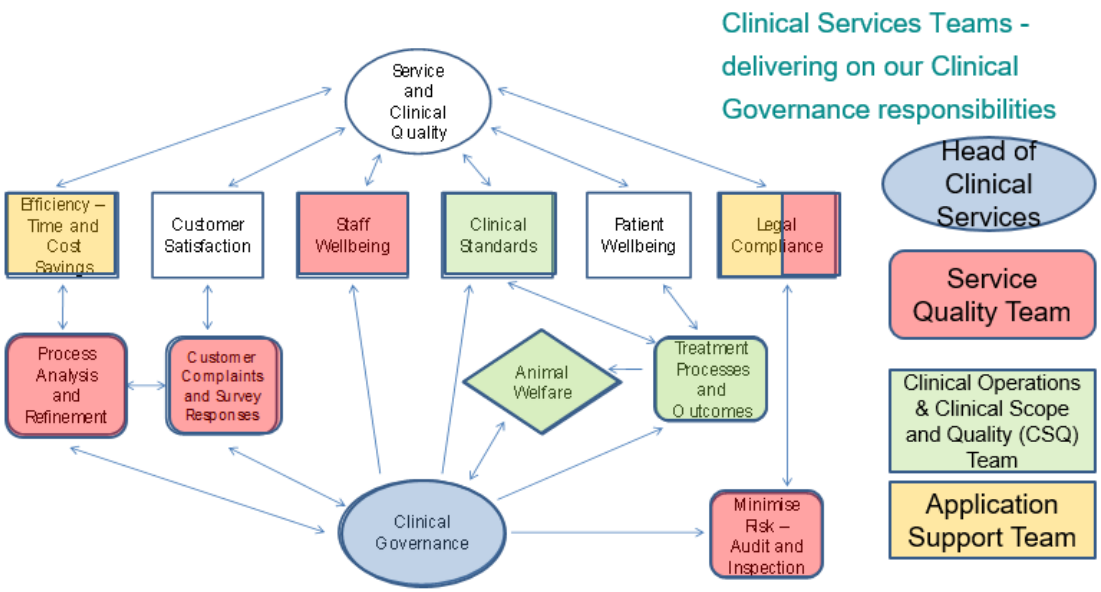
Introduction

PDSA was established in 1917 to help ensure no pet suffered needlessly. Since that time, PDSA has grown into the UK's leading veterinary charity, helping pets and their owners in need every day. Our vet teams provide vital, life-saving care to 470,000 pets every year through 48 Pet Hospitals across the UK. As PDSA has grown, the risks associated with delivering a veterinary service on such a scale have also grown. There has also been an increasing duty to all of its stakeholders (clients, patients, employees, volunteers, supporters, donors, Trustees and the charity commission) to demonstrate that charitable funds are used as effectively as possible. Therefore the PDSA veterinary service must be:

- Defined in scope, breadth and depth
- Delivering an appropriate standard of clinical and customer service
- Operating within regulatory and legislative requirements
- Operating as effectively as possible
- Delivering the pet welfare outcomes and client care required
- Identifying and mitigating risks associated with delivering a veterinary service

In order to demonstrate this, PDSA has established and operated within a clinical governance/quality improvement (QI) framework.

PDSA has appointed Head of Clinical Services (HoCS) who leads continued development of those frameworks and has established teams specifically structured to address relevant areas, as illustrated below:



The establishment, management and activities of these teams, all focused on service quality improvement and risk identification and mitigation, represents a significant investment by PDSA in QI frameworks and initiatives. This level of commitment is possible through having buy-in to the concepts at the highest levels and has made it possible to undertake considerable levels of activity in this area over a number of years. HoCS is required to provide a report to PDSA Trustees annually, documenting clinical governance activities and identifying risks or governance gaps for future attention.

Aims

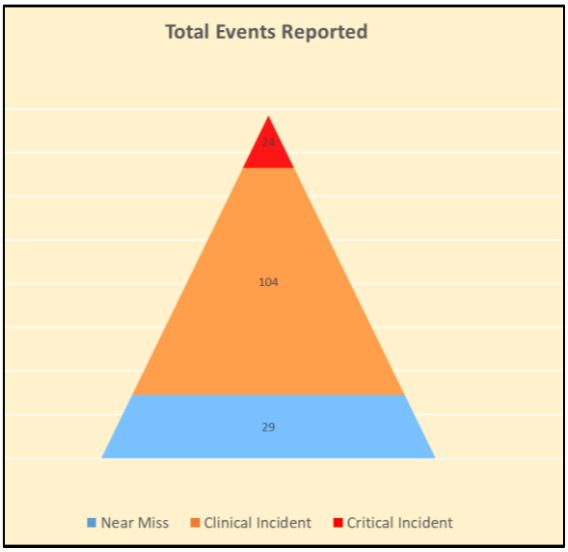
PDSA introduced an online national clinical incident-reporting platform in 2017, and focus has since been on encouraging a culture of openness, which would facilitate the reporting and discussion of adverse events, learning from adverse events and interventions designed to reduce their frequency.

Actions

The Service Quality Team analysed reported clinical incidents to breakdown the types of incident and their root cause. They then passed those results to the Clinical Operations and Clinical Scope and Quality (CSQ) team to formulate interventions that address the root cause of the incidents. The relatively low volume of near miss reporting was noted; Heinrich's safety pyramid would suggest that the level of near misses reported should exceed incidents significantly.

Results

During 2019, the number of reports reached a level where trends could be identified, and targeted plans could be created to identify and address areas of risk most likely to result in clinical incidents and harm to patients. Approximately 39% of all clinical incidents reported arise from the dispensing process. In addition to this, a number of Veterinary Medicines Directorate (VMD) inspections have highlighted variances in dispensing behaviours and processes across sites. Analysis of NHS data suggested that their proportion of incidents reported relating to dispensing was at approx. 10% and that further action was required.



Impact of intervention

The findings of the clinical incident report analysis stimulated the CSQ team to establish a small working party to review and refresh the existing guidance, in relation to the dispensing of medication and associated checks and controls.

The impact of introducing clinical incident reporting has been the ability to target interventions to areas that present the highest risk to both our patients and staff. The impact of incorrectly dispensed medication can be devastating from a patient wellbeing, client emotional and staff wellbeing perspective if the worst were to happen.

Following cascade of the refreshed guidance, checks and controls reported clinical incidents relating to dispensing will be monitored to ensure that the desired reduction has been achieved. The platform that enabled highlighting of the issue in the first place will also provide valuable evidence of the effectiveness and impact of targeted interventions.