Significant Event Audit Case example: Controlled drugs register

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

A Significant Event Audit (SEA) is 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 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. It is important that the event is discussed without any blame – allowing team members to provide honest and constructive feedback on how they contributed to the care process. An SEA is completed in 6 stages. The following points will take you through the steps that this practice took to put an SEA into practise.

1. Identify the significant event

Create a brief description of the event, context and outcome to be discussed in the meeting.
The total amount recorded in the controlled drugs register was more than the amount in stock.

2. Collect all the relevant information

Gather all relevant information, such as case files and staff accounts etc., which contribute to the case.
A significant event audit was completed. Information was collected from the team members involved with the patient; the team members working on site; the hospital sheets and records and the veterinary surgeons directly 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, for example by using The 5 whys strategy or root cause analysis, plus identifying contributory factors. Any discussion should be kind and constructive.
A meeting was led by the Veterinary surgeon that identified the error. The results of the meeting were split into factors that affected the overall results. These were system, human, patient, owner, communication and other. This helps to create a blame-free meeting, looking at all contributions and getting input from all member of the team.

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.

An improved protocol needed to be created for the recording of controlled drugs.

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.

A new protocol for the recording of controlled drugs was implemented, this included having one person responsible for the register.

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 audit may be required to monitor the change.

A process audit will be completed monthly.

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Section B: A significant event audit on the recording of controlled drugs

QI Vets
PATIENT OUTCOMES FIRST

Title:	Significant event audit on the recording of controlled drugs
Date of significant event:	21/02/2019
Date of meeting:	08/03/2019
Meeting lead:	Julia
Team members present	The whole practice team; Vets, RVNs, ACAs & Receptionists

What happened?

It was the middle of morning surgery at the branch practice, when Nicola was presented with a Labrador with an acute abdomen. She had a high pain score and after assessing her major body systems she wanted to provide suitable pain relief immediately. She went to the controlled drugs cabinet and reached for the methadone bottle, only to find that there wasn't one open. As she opened the new bottle she flicked to the correct page of the controlled drugs register to see the running total was 17.5mls. She administered the methadone to the Labrador and admitted her for further diagnostics, then returned to sign the dose out of the register. A quick search through the cabinet didn't reveal another bottle of methadone so she left the running total blank and vowed to return to it later that morning.

The morning was busy and Nicola ended up taking the Labrador to surgery with a linear foreign body which had perforated. After a briefly snatched sandwich, luckily afternoon appointments were quieter so she returned to the register. A more thorough search still didn't reveal another bottle of methadone.
She looked back to see where the weekly reconciliations had been done and was disappointed to find that there hadn't been one for the past 4 weeks. It seemed two had got missed due to annual leave and one she had forgotten to do herself. She spoke to the other vet Julia and their regular locum David and nobody could recall any missed doses. Luckily they could run a report on their practice management system of when methadone had been charged and found two of the doses, but around 2.5mls still remained unaccounted for. Sadly the trio had to spend some time one evening going through the hospitalisation records and eventually found a dose that had been missed from the register and not recorded on the PMS, finally the register balanced although it looked rather disorganised.

<u>At the SEA meeting we found out the following</u>

Julia and Nicola shared accountability for the weekly checks on the register at the branch practice, and had agreed to alternate though because this wasn't written down anywhere it was easily disrupted by a change in schedule such as annual leave. Both Julia and Nicola each thought the other had asked David to do the checks on two occasions, but it turned out neither of them had remembered to. As the checks weren't done on a regular day it was very easy to forget.

Both vets felt that the shared responsibility had meant they were lulled into a false sense of security and had both become more relaxed about recording in the register at the time the doses were given which led to a couple of missed entries.
On a couple of occasions all the vets admitted to leaving the key in the cabinet door when it was busy for ease of access which had heightened their concern that someone else could have accessed the cabinet – they had recently had an open day and couldn't recall with clarity exactly where the key was at that time.

Why did it happen?

System factors:	· No one person was accountable for the controlled drugs process · A lack of defined process for the weekly reconciliation had led to omissions being missed for a period of time.
Human factors:	· The team were busy dealing with multiple patients at once. · Julia was feeling stressed and very much looked forward to her holiday so didn't take the time to double check the register before she went on leave, or ensure processes were in place for checking while she was off.
Patient factors:	· None
Owner factors:	· None.
Communication factors:	· Lack of clarity of communication led to neither permanent vet alerting the locum to what was expected of him in terms of reconciliation.
Other:	· A culture of being less rigorous with register entries had developed. · It turned out that the student VN had noticed the key being left in the cabinet on two occasions but didn't want to speak up for fear of being seen as critical of the vets.

What has been learned?

The whole team were very relieved that they found the missing doses and reconciled the register, they realised had they been unable to do so they would have had to inform the police and the practice standards inspectors and it would have become more widely known that their practices had fallen short of ensuring safe custody of the controlled drugs at all times.

They were saddened to feel their safety culture in this area had slipped – they recognised the importance of fulfilling their legal and professional obligations, and also safeguarding the wellbeing of their colleagues and members of the public.

They also reassured the student VN her views on all processes and practices within the clinic were welcomed.

What has been changed?

CPD/training required:	· The vets refreshed themselves on their legal responsibilities in this area.
New or updated protocols/checklists/guidelines:	· A protocol for increased reconciliation and audit were implemented. · It was decided that Julia would have overall responsibility for the controlled drugs process and register and it was her responsibility to delegate it when she wasn't there. Although Julia is not the Clinical Director (CD) of the practice, the CD rarely worked at the branch and has many other responsibilities, when asked, Julia was keen to take this responsibility on herself. · All team members agreed to write doses in the register immediately after administration (as long as animal welfare wasn't compromised).
Further audit required?	· The team decided to increase the reconciliation of all controlled drugs against the register twice weekly and then undertook a process audit monthly to ensure the twice weekly checks were being performed accurately. · The team also reconciled the register against the usage report from the PMS as well as the amount of drugs present.
Other:	· None

Follow-up date

Today's date:	08/03/2019
Review date:	08/04/2019
Signature:	