Significant Event Audit Case Example: Near miss in the dispensary

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.
A locum veterinary surgeon prescribed the wrong size enrofloxacin tablets for a feline patient. The mistake was identified as the tablets were bring handed to the client, and they were replaced with the correct ones.

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 and the patients owner.

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 receptionist and the veterinary surgeon. 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 dispensing of all medication. Thorough inductions for new and locum members of the team needed to be implemented.

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 dispensing of medication was implemented, this included having prescriptions double checked by a second person.

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. This audit will be of the dispensing protocol, the double initialling of medications and of client waiting times.

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Section B: Significant event audit after a near miss in the dispensary

QI Vets
PATIENT OUTCOMES FIRST

Title:	Significant event audit after a near miss in the dispensary
Date of significant event:	21/02/2020
Date of meeting:	08/03/2020
Meeting lead:	David and Andrew
Team members present	The whole practice team; Vets, RVNs, ACAs & Receptionists

What happened?

Mr Smith, who is 82 but very fit apart from arthritis, brought his old cat Fred into the surgery with an abscess following a cat bite. He saw a locum vet, David. David prescribed Enrofloxacin tablets.
A new SVN, Harriet, who started at the practice that week put up the tablets according to the instructions on the label. Mr Smith got to reception and told the receptionist that he did not think that he could give tablets to Fred.
The eagle eyed receptionist, Andrew, who had been at the practice 20 years noticed they were 150mg tablets instead of 15mg. he went to see the vet, who got Mr Smith & Fred back in and gave a long acting antibiotic injection and arranged to see Fred back in 48 hours. Andrew recorded this incident in the "near miss" book in the Dispensary.

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

David was really busy that morning, his appointments were double booked and was in a bad mood as his car had broken down on the way to work and he was worried how much the repair was going to cost . He had left his glasses in the car but luckily had his spare reading glasses with him.

Harriet had not had any formal induction as the head nurse was off sick. She had not worked in the dispensary before but the practice was very short staffed that day. She had never worked with David before. She had questioned a couple of things earlier but he had been very short with her. She wasn't sure that the tablets were correct but was reluctant to say anything.

Andrew said Mr Smith told him on reception he had no chance of getting tablets down Fred, when he looked at the tablets he immediately saw they had a dog picture on as they were in a clear plastic bag.

Andrew went through & told David who was very embarrassed & upset that he had clicked on the wrong drop down box.

Why did it happen?

System factors:
- No induction for Harriet.
- No dispensary training for Harriet.
- No clear dispensing SOPs.
- No double checking of tablets by a second person.
- Antibiotic prescribing policy not shared with locum team members.

Human factors:
- The team were busy, understaffed and rushed.
- David was distracted by external matters.
- The team had not worked together before or regularly enough.

Patient factors:
- None

Owner factors:
- Mr Smith had not told David in the consultation that he could not give Fred tablets.

Communication factors:
- Lack of communication between Mr Smith and David.
- David was not asking whether Fred would take the tablets.
- Poor communication between colleagues, especially David and Harriet.

Other:
- Practice culture that junior nurses are not listened too.
- Locums are not included in practice discussions and resulting policies not shared with them.

What has been learned?

David was very embarrassed by the whole incident. In the discussion other vets admitted they had found the drop down boxes fiddly too and it had nearly happened to them. He felt better after the discussion.

David apologised to Harriet and said he always valued nurses' opinions but was distracted that day.
The practice manager agreed to review the appointment scheduling once she had information from the client waiting times audit in view of overbooking at busy times.

The whole team congratulated Andrew on spotting the error and pointing it out politely to David so it could be rectified and no harm was caused. The valuable role of Reception in being the last check with medicines was pointed out to the whole team.

What has been changed?

CPD/training required:
- Team training on dispensing protocol.
- Better inductions/ shadowing for all team members.
- Team members not to be put in situations they are not trained for.
- Senior nurse put in charge of dispensary and to organise team training.
- Communication training for the whole team.
- Training in the responsible use of antimicrobials.

New or updated protocols/checklists/guidelines:
- New protocol on dispensing.
- Introduction of double initialling system for dispensed medications.
- Updated Protect poster after team meeting with all vets, including locums.

Further audit required?	· Process audit of how team were complying with dispensing protocol. · Audit of double initialling medications. · Audit of client waiting times.
Other:	· Contact database provider to query making the drop down boxes bigger/ clearer. · Improving practice culture so that everyone's voice is listened to equally. · Sizes on packs of medicines highlighted and different sizes clearly separated. This was not the cause on this occasion, but might have been if the correct box was ticked but the wrong medicine chosen.

Follow-up date

Today's date:	08/03/2020
Review date:	08/04/2020
Signature:	