Significant Event Audit Case Example: Cardiopulmonary resuscitation on a patient

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

A Significant Event Audit (SEA) 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.

Steve the German Shepherd had been hospitalised for a week after an emergency cystotomy to remove an obstructing tumour. Towards the end of the day Steve suffered from cardiorespiratory arrest however all efforts to revive him were unsuccessful.

2. Collect all the relevant information

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

Information was collected from the hospital sheet, clinical records, the veterinary team involved and the 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 encourage to speak freely and honestly.

A meeting was conducted the following day with all team members. Steve was a critical patient, who was at high risk of cardiorespiratory arrest. The processes in place were successful in assisting the team to provide the care that was required.

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.

After discussing the case, no further changes needed to be made.

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 incident was shared with other team members through meetings and individual one-to-ones.

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.

The existing protocols will be reviewed if there is another significant event.

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Section B: Significant event audit after cardiopulmonary resuscitation was performed.

Title:	Significant event audit for CPR within the kennel room
Date of significant event:	07/11/2018
Date of meeting:	08/11/2018
Meeting lead:	Nursing Manager
Team members present:	The whole practice team; Vets, RVNs, ACAs & Receptionists

What happened?

Steve, a German shepherd dog had been in the hospital all week after a cystotomy to remove a mass that that was blocking his urethra. He was a geriatric patient that was also suffering with arthritis, renal failure and haemorrhagic diarrhoea on top of having to recover from the emergency surgery and any potential systemic diseases. Steve was intensively nursed all week, and was showing small signs of improvement. However one evening when his owner was visiting Steve went into cardiorespiratory arrest.

A Registered Veterinary nurse (RVN) and a Student Veterinary Nurse (SVN) were in the kennel room at the time. While the RVN began Cardio-Pulmonary Resuscitation (CPR) the SVN went to get more help. An emergency crash kit in the kennel area allowed the patient to be intubated and for supplemental oxygen and adrenaline to be given. Two more team members assisted with the resuscitation efforts; a RVN giving chest compressions, a RVN providing intermittent positive pressure ventilation (IPPV) and a SVN monitoring clinical parameters, while the Veterinary Surgeon (VS) administered and recorded medication and fluids. Although a heart rate returned three times, it could not be maintained and Steve passed away.

Although the owner was understandably upset, she praised the team for their quick treatment. The VS commended the team for their fast action and rotation of CPR roles, which allowed them to maintain constant supportive care for the patient. When the owner was spending some time with Steve, the team took some time away from the room to regroup after the loss of a popular patient.

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

The nursing team within the kennels acted quickly and efficiently. They communicated well between each other, allowing for care of the patient, and help to be sought. The recent addition of an emergency crash kit within the kennel room allowed for the administration of oxygen to be started immediately and for chest compressions to be started. The protocol of the emergency crash kit had been implemented after recent CPR training that was provided to all staff members. When further assistance arrived, communication was quick and effective, enabling monitoring equipment, medication and CPR to be continued. One of the veterinary nurses, who was setting up the equipment, mentioned that she was not confident with reading the Electrocardiogram (ECG). During the meeting she thanked everyone for swapping so that roles were efficiently covered, and her other skills could be utilised.

Members of the team that were not directly involved with Steve ensured that his owner was taken somewhere quiet. They were able to call a family member for support and provide cups of tea. This was important for the client's emotional wellbeing.

Why did it happen?

System factors:	- The implementation of emergency protocols allowed for the required equipment to be easily obtainable. - Recent training had refreshed the team's memory on the most effective way to act in this scenario.
Human factors:	- Effective communication within the team allowed for fast action. - An effective learning culture allowed team members to admit when they were not confident with a task, allowing roles to be swapped to better help the patient.
Patient factors:	- The patient was suffering from a number of systemic diseases. Although he had showed improvement that day, his deterioration was not a surprise.
Owner factors:	- The owner was kept well informed, and was in the next room while the team worked on Steve.
Communication factors:	- Communication was effective. Team members spoke to each other and updated each other on what was required, and what the patient's status was. - Communication was also effective after the patient passed. Allowing for team members to have time away from the clinical floor to come to terms with the event. - The reception team were informed of the incident at the time. This enabled them to explain any delays to other appointments, and also to give the owner the support she required.
Other:	- The whole team worked together towards a united goal. Even though the efforts were unsuccessful, they worked together afterwards to support each other's emotional and physical wellbeing.

What has been learned?

The provision of CPR training was useful, and it is something that will be continued on a regular basis. The practice has many part time members of staff, and a refresher course was helpful to everyone.

The recently implemented protocols of an emergency crash box within the kennel room proved valuable in this situation, this was to be kept in place.

The united front the team showed how important good communication and trust is between colleagues. This was to be supported through team meetings and individual appraisals.

The team identified the deterioration of Steve quickly and effectively, and not only treated him, but ensured the owner was cared for also.

Overall, although Steve passed away, the response and actions by the team were positive.

What has been changed?

CPD/training required:	- CPR training to be continued on a regular basis. - One-on-one training was to be given to team members who were not confident on certain aspects. Although this did not affect this particular event.
New or updated protocols/checklists/guidelines:	- The current protocols were helpful
Further audit required?	- None
Other:	- None

Interested in submitting your own case example? Email us at ebvm@rcvsknowledge.org