Seven Practical Steps for SEA

In preparing and planning SEA, the GP team should follow seven different stages in the identification, investigation and analysis of a significant event. Closely adhering to each stage of the process helps to ensure that the team undertakes a more in-depth and enjoyable SEA experience, rather than engaging in a superficial, informal and unstructured discussion.

Step 1: Awareness and Prioritisation of a Significant Event

- Staff should be confident in their ability to identify a significant event when it happens (see Appendix 1 for examples).
- The practice is fully committed to the routine and regular audit of significant events either through dedicated meetings or as an agenda item at other practice meetings.
- The practice has a simple computer or paper-based system for logging all significant events identified by clinicians and staff.
- Designated practice staff can be consulted by others and are able to make a judgement on whether a specific significant event requires to be formally audited immediately, at the next routine meeting or can be dealt with in a simpler way. Alternatively, all possible events are listed and the prioritization, if required, takes place at the start of the routine SEA meeting.

General Guidance on Topic Selection for SEA

- Significant events should be selected and prioritised for audit based on their consequences (actual or potential) for the quality and safety of patient care. The opportunity for learning and improvement – where required - should also be clearly apparent. Not all significant events require to be formally audited. A decision on whether a significant event should be formally audited could be made after discussion with colleagues.

- Events which are concerned with under-performance, contractual or personal issues should be dealt with by existing practice mechanisms rather than through SEA.

- Some events, particularly clinical examples, will undoubtedly be highly sensitive and GPs may not be prepared to highlight these to the whole practice team, especially if team-based input is not necessarily relevant or required. This is fine as long as the SEA process is still applied in conjunction with close clinical colleagues and that insight, learning and necessary change are demonstrated. In the past, analysis of these events may have been avoided and taken off the SEA agenda. However, in the current climate where learning from patient safety incidents is paramount these types of events can no longer be ignored.

- Events selected for audit may be heavily clinical in nature which tends to alienate non-clinical staff. Be flexible – there is nothing to stop administrative staff meeting as a group occasionally to audit administrative significant events and reporting the outcomes at future full team-based meetings.

- Ultimately it is for each team to decide who is invited. While the doctors, nurses (practice and community) and senior managers are normally invited, a head receptionist might also be present. There has to be a balance between all those who can contribute to an honest

discussion and creating such a large group that discussion of sensitive issues, such as clinical errors, is inhibited.

Step 2: Information Gathering

The information gathering process can begin immediately after the event, just prior to the routine SEA meeting, or it can happen during the meeting from the personal testimony of those with the greatest knowledge of the event. Where time permits, the team should attempt to determine exactly what happened, how it happened and why for each event before the routine meeting (see Step 4 - the Glasgow Grid). This may be particularly important for serious or complicated events in order to allocate greater time at the meeting to understanding the causes of these events and agreeing action points. Individual(s) involved, directly or indirectly in the event, may be best placed to lead the investigation but others can also be delegated this task.

Collect and collate as much **factual information** on the actual event as possible, from personal testimonies, written records and other clinical documentation. This is necessary in order to build a chronological timeline of the key factors which contributed to the significant event. Personal testimony will be gathered through the thoughts, opinions and impressions of those directly and indirectly involved including (where relevant) patients and relatives or health professionals from outwith the immediate team.

Occasionally when an event is discussed at a team meeting it may become obvious that it is too complex to be immediately understood and resolved. The outcome of the meeting is a recommendation that a more in-depth investigation is therefore required (see Appendix 2).

Common Information Sources:

- Case records, laboratory reports, letters of complaint, practice protocols and other relevant documentation.
- Personal testimony from patients, relatives, health care staff and individuals from other agencies.

Step 3 – The Team-based Meeting

SEA normally involves a routine meeting of all relevant team members* to discuss, investigate and analyse the significant event(s). The team-based meeting is the key function in coordinating the SEA process. This is where most of the learning and change will take place.

These meetings should be held regularly – for example, a dedicated monthly get-together over lunchtime or as part of another practice team meeting. Set aside at least 1 hour for the meeting. Some minor significant events can often be dealt with quickly without much detailed analysis. Others will be much more challenging.

The key to effective SEA is that detailed discussion of each event takes place, insightful analysis is demonstrated and, where appropriate, learning needs are identified. Relevant action should be agreed based on these analyses. The meeting should be conducted in an open, fair, honest and non-threatening atmosphere – this is the core essence and spirit of SEA. Failure to do so will hamper the entire SEA process. Where there is a fear of blame and potential punishment, then team members will become reluctant to engage in the process and more likely to withhold important information about events. The greatest resource in terms of knowledge, understanding, skills, innovation and effectiveness is the team itself. SEA thrives on this. Without these inputs from the team, then SEA will simply flounder.

A minute of the meeting – outlining agreed learning points and actions to be taken by individual staff - should always be taken and circulated afterwards to all staff, including those not able to attend.

Good Practice for Team-Based SEA Meetings:

- SEA can be undertaken at dedicated monthly meetings or as part of regular team-based meetings. Protected time should be set aside to allow detailed discussion and in-depth investigation of events. More serious events should be discussed at specially convened meetings as soon as possible after they happen. Remember to rotate meetings so that part-time staff also have the chance to participate.

- The ground rules for meetings should be agreed and made explicit to team members beforehand, particularly in respecting opinions, not apportioning 'blame' and reinforcing the educational purpose of the meeting.

- Success is heavily reliant on positive team dynamics and interaction. A well-established, strong and cohesive team displaying a high degree of maturity, trust and openness will be well placed to apply the SEA technique effectively. Confidence that frank discussion will not exacerbate interpersonal problems is required.

- Teams need to be assured (perhaps regularly) that the SEA process is not about allocating blame but is about gaining a full understanding of why events occur and learning from them. More often than not it will be practice systems and procedures which are deficient – with unfortunate individuals caught up in the process. Where fear of being open and honest about events is apparent because of potential embarrassment and reprisal then SEA will always flounder.

- Participants should always refrain from direct personal blame or criticism. Participants need to be clear that discussion and individual feedback should always be **positive, fair, constructive and sensitive**.

- Enthusiastic, well-respected and (preferably) trained individuals should be used to promote, co-ordinate and facilitate SEA meetings at the outset.

- Strong leadership/facilitation is important in running meetings to time, gaining co-operation and agreement, encouraging participation by all members of the team, exposing hidden agendas and in ensuring meetings are not always dominated by a few individuals, particularly medical staff. Employed staff may also feel low in the hierarchy, find it difficult to act confidently as equals and feel vulnerable to speaking out.

- Once the team meetings are well established and team members become more confident and at ease with the process, it may be helpful to rotate the facilitator.

* Ideally SEA should be a collaborative team effort. However, the guidance provided here can easily be adapted by the individual practitioner for Appraisal purposes to reflect on a significant event that is personal to them.

Step 4 – Investigation and Analysis of the Significant Event

The entire process for investigating and analysing a significant event should be guided by answering the following four key questions:

1. What Happened?

- Establish what, how and where the event happened in detailed, chronological order.
- Focus on collecting as much factual information as possible from: written and computer records; personal testimony from those team members directly and indirectly involved, patients, relatives and colleagues from NHS bodies and other agencies.
- Determine what the impact was or could have been (both positive and negative) e.g. clinically and/or emotionally for the patient, the professionalism of individuals or the team, or the liability of the organisation.

2. Why did it happen?

- Establish the main and underlying reasons – positive and negative – contributing to why the event happened. Identify the problems in administrative, care and systems processes that led to the event. For example, these may include – for whatever reasons – things that should have happened but did not, or did happen as intended but something else unexpected interfered with the process.
- Where necessary, in order to facilitate learning, change and potential improvement consider applying the Glasgow Grid* or similar technique either before or during a team-based SEA meeting to gain a more in-depth understanding of the reasons and/or causal factors contributing to an event.
- Consider, for instance, the professionalism of the team, the lack of a system or a failing in a system, lack of knowledge or the complexity and uncertainty associated with the event.

- Alternatively, if it is a positive event what were the underlying factors that contributed to a successful outcome?

*** The Glasgow Grid** (Appendix 3) is a synthesis of the existing SEA educational framework developed by NHS Education for Scotland (NES) and Toyoda's '5 Whys' – a basic problem solving technique endorsed by the NPSA and which is used to determine the root causes of a defect or problem. Gaining a comprehensive understanding of why an event happened is vital to subsequent learning, change and improvement. Application of the Grid by a health care team prior to or during a meeting as part of a 'brain-storming' session is a core element of the SEA method outlined and highly important in ensuring a more rigorous and robust process is being adhered to. An alternative approach to attempting to understand the causal factors associated with an event involves the use of the 'Fishbone Diagram' which can be access via the NPSA website www.npsa.nhs.uk.

3. What has been learned?

- Based on the reasons established as to why the event happened, outline the learning needs identified – if any - from the event.
- Demonstrate that reflection and learning have taken place on an individual or team basis and that relevant team members have been involved in the analysis of the event
- Consider, for instance: a lack of knowledge & training; the need to follow systems or procedures; the vital importance of team working or effective communication.

4. What has been changed or actioned?

- Based on the understanding of why the event happened and the identification of learning needs, outline the action(s) agreed and implemented (where this is relevant or feasible).
- Action is not always necessary – particularly for positive and purely reflective events – but should always be considered and justifiably ruled out if not necessary.
- Consider, for instance: if a protocol has been amended, updated or introduced; how was this done and who was involved; how will this change be monitored. It is also good practice to attach any documentary evidence of change to the subsequent SEA report e.g. a letter of apology to a patient or a new protocol.
- Consider also how this SEA could be shared and if the event meets the criteria to be formally reported.

Possible Outcomes of a Significant Event Meeting:

• **Celebration:**	Often the care and service provided are shown to be exemplary. For example, the team-based effort in successfully resuscitating and elderly man who collapsed in the surgery waiting room.

• **No Action:**	The event is part of everyday practice or is so unlikely to ever happen again that it would not be an effective use of time and resources putting preventative measures in place.
• **A Learning Need**	A patient's sudden collapse in the surgery revealed that the nurse and doctor who attended needed refresher training in CPR. Other team members agreed they needed it too and a session was arranged.
• **A Learning Point**	A discharge summary was received in the practice but the prescriptions on the practice computer were not changed. An out-of-hours doctor had to sort out the problem and the patient complained. The doctors agreed to be more careful in responding to new discharge summaries.
• **A Conventional Audit is required**	A problem is revealed, but the team is unsure how common it is. For example, a 49 year-old over-weight patient and smoker is admitted to the local hospital with an MI. Review of his records shows that he was at risk but was not on appropriate medication.
• **Immediate Change**	A child was given an out-of-date vaccination prompting a complaint from the parents. The practice had an ad-hoc arrangement for monitoring vaccinations. A formal protocol was introduced immediately to ensure regular checking of vaccinations and refrigerator temperatures by designated staff.
• **Full Investigation: In-depth SEA Required**	The team discussed an apparent missing blood test result which had been ordered for an elderly man who was subsequently hospitalised with anaemia. It was unclear why this had happened. The GP who ordered the test and the practice manager would jointly undertake an SEA to fully investigate.
• **Root Cause Analysis**	A serious patient safety incident has occurred. For example, a young child who attended the practice with exacerbation of asthma symptoms, died from an asthmatic attack after being sent home, rather than to hospital as the parent had suggested based on past experiences. The local primary care trust/NHS authority may seek to carry out an independent and external Root Cause Analysis of this incident in conjunction with the practice.
• **Sharing the learning**	As well as sharing the SEA amongst colleagues in the immediate practice, consideration should also be given to sharing both the circumstances surrounding the event and the associate learning gained from the analysis with any local forums (e.g. GP Trainers' Groups, the local health centre, CPD and PLT meetings…)

Step 5 – Agree, Implement and Monitor Change

All SEA meetings should start with looking at agreed actions in the minutes of the last or previous meetings. Action that is agreed as part of SEA should be implemented by those staff designated to co-ordinate and monitor change in the same way the practice would alter practice as a result of the 'traditional' audit process. A timescale for change should always be built-in to the process. Progress with the implementation of change should always be monitored by placing it on the agenda for future team or significant event meetings. In this way, confirmation that the change has been implemented can be made or any difficulties in

this area can be discussed and overcome with the help of the team. Where it is required, the implementation and monitoring of change is vital to the success of SEA. Like traditional audit, failure to consider change that is necessary of to implement it properly are common barriers to effective SEA in general practice.

Step 6 – Write-It-Up

Keep a written record of every SEA undertaken using the well-established standardised report format outlined in Appendix 4. Remember that SEA is a retrospective technique. Any change or action described in a completed report should already have happened or be in progress rather than simply being suggested or wished for.

The SEA Written Report:

A comprehensive SEA report needs to written as soon as possible after the investigation is completed. When writing a report, bear in mind that it needs to be a sufficiently detailed account of the entire investigation process, which should cover the following four key areas:

- What happened?
- Why it happened?
- What was learned?
- What was changed? (where appropriate).

The written report is a window on the entire SEA process. If it does not reflect the necessary depth of analysis that the significant event merited, then it is entirely possible that QoF Assessors, GP Appraisers or Educators will raise concerns with the standard of the SEA. Regardless of whether a different report format is in use, detailed information on the four key areas shown above must be included. It is good practice to avoid using **any identifying information** for the patients, members of staff or agencies involved in the event i.e. don't use first or second names – instead use codenames like 'Patient X', 'Dr A' or 'Nurse Y'.

Stakeholders who may expect to see a SEA report include:

- Patients and carers
- Educational peer reviewers
- QoF Assessors
- GP Appraisers
- Clinical governance committees
- Local NHS authority (in England, the Primary Care Trust)
- Primary Care Trust

Step 7 – Report, Share and Review

Report and Share the Learning from Significant Events

Reporting when things go wrong is essential in general practice. The practice will be required to report a proportion of significant events, particularly those where the safety of a patient has been compromised. When this has happened it is tempting to explain it as the product of negligence, incompetence or carelessness on the part of staff, or as a rare misfortune that is neither predictable nor preventable. But experience from other complex high technology settings, such as the aviation industry, has shown that safety incidents are not simply the result of human mistakes, such as inattention or forgetfulness. Nor are they random or rare – in fact certain organisational and cultural factors can make them more likely to happen.

Also, where such a mechanism exists, confidential SEA reports should be passed to local clinical governance leads so there may be an opportunity for lessons learned to be shared with others.

For staff and primary care contractors to feel comfortable reporting significant events or incidents, they must have confidence in the culture: that it is open and fair, and that staff can feel able to speak up when they have concerns, and where they know they will be treated fairly if they do so. Creating, nurturing and sustaining that culture is a responsibility of each and every one of us; as is the responsibility to report significant events and patient safety incidents.

Nominate a lead to complete a report. Share the learning with others. In some cases the primary care organisation is required to report significant events to external organisations.

External organisations that might require a report include:

- CHP/NHS Board
- Medicines and Healthcare products Regulatory Agency (MHRA);
- Health and Safety Executive through RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations);

Educational Peer Review and Feedback

It is good practice to get outside feedback on the overall standard of an SEA that is undertaken by the practice team. Peer review is one method of doing this and is recommended where this type of educational model exists. Most GPs' experiences of peer review will be when it is applied in an informal, unstructured and non-judgmental manner. Typically this would happen when colleagues meet in small groups to discuss audit findings or

to seek professional guidance or review decision making associated with interesting or complicated episodes of patient care.

Definition:

Peer review has been described as the *formative evaluation of one element of an individual's performance by trained professional colleagues, which is normally achieved using a reliable and valid feedback instrument*.

In the case of SEA, a formal and structured peer review process would enable informed and trained GP colleagues to comment on the standard of this activity. Educational feedback would be provided that is specific, informative, sensitive, and directed towards improving the SEA under review and the submitting GP's overall knowledge of the SEA technique - where this is required.

In NHS Scotland, a peer review model which is based firmly on educational principles has been aligned with the SEA process. The model allows GPs and practices to submit their SEA reports to the regional deanery in strict confidence as part of arrangements for continuing professional development. The reports are scanned for confidentiality issues and then sent to two peer reviewers chosen at random from a small group trained GPs. Each reviewer independently assesses the SEA report using a content valid feedback instrument and returns it to the deanery. The feedback is collated and a written report returned to the submitting GP or practice for their consideration.

Participation is voluntary but is strongly encouraged as one way for GPs to provide objective evidence of performance for appraisal purposes and as an external check on the 'quality' of SEAs undertaken for clinical governance purposes. Importantly, the process can be used to assist GP trainers in tutorials to facilitate educational feedback on SEA undertaken by GP registrars.

APPENDIX 1

Examples of significant events

Case Study 1

A patient is prescribed a drug which has the potential to interact with their current medication: this is noticed by the community pharmacist who, following a call to the practice, does not dispense the medication and informs the patient they need to return to the GP who will prescribe another medication.

Case Study 2

An elderly patient whose husband had COPD rang the practice to speak to a Doctor at 9.10am regarding his increasing distress and breathlessness – the phone was engaged for 40 minutes and the home help also tried without success. An ambulance was eventually called and the patient died in hospital later that day. A complaint was subsequently received by the practice.

Case Study 3

A GP was out on a visit and received a telephone call to visit a child in the next street who was unwell and couldn't come to the surgery. The grandmother is looking after the child and states that the child is not allergic to anything. The GP prescribes penicillin. On return to the surgery the GP enters the information on the computer and notices that the child is allergic to penicillin. The grandmother is contacted and, as the prescription has not been dispensed, an alternative drug is prescribed.

Case Study 4

The GP dictates referral letters at the end of a surgery using a hand-held dictation machine. When the typist later puts the dictation tape in the machine it is blank. The wrong tape was handed over. The correct tape has been used again for another surgery, over-writing the original dictation for that surgery's referrals.

Case Study 5

The practice nurse does a smear test on Mrs W and informs her that she will be notified if there are any problems with the results. The result comes back abnormal and the practice tries to contact Mrs W but there is no record of a telephone number and she is ex-directory. A letter is sent but this is returned and it becomes apparent that Mrs W has moved and not notified the surgery. Meanwhile, Mrs W assumes that as she hasn't heard then the result must be normal. Six months later Mrs W comes to the surgery on a routine appointment and is informed of the result and referred.

Case Study 6

A patient was referred to a rheumatologist because of arthritic symptoms. The rheumatologist diagnosed rheumatoid arthritis and asked for the patient to be commenced on sulphasalazine. The patient was given a prescription for 1-month supply of the drug and told that it would be put on repeat prescription. The patient phoned in to obtain a repeat prescription 3 months in a row, but the repeat prescription has been entered as sulphadiazine instead of sulphasalazine. He therefore had 3 months of sulphadiazine in error prior to the mistake being identified.

Case Study 7

A patient told the nurse she would not be in on the following day because she was going out with her family. Her family would instil eye drops. The nurse forgot to pass the message onto colleagues. The visiting nurse therefore spent a lot of time tracking down the family to find out why the elderly lady was not in. The police were almost called to break in.

Case Study 8

In GP surgery Y, a mother of a four year old boy due to start school had been discussing the MMR (Measles, Mumps and Rubella) vaccination with the GP. She and her husband have delayed giving their son the MMR vaccine as they are very worried about all that they have read in the papers about possible side-effects. They are not convinced that their son should have it as he was a “poorly baby”. The doctor documents their decision. The parents know their son needs his pre-school booster vaccinations and they are happy for those to go ahead. Following notification by the automatic notification system that the vaccinations are due, the mother and son turn up at the immunisation clinic and wait their turn. The practice nurse checks the boy’s appointment card, which has generated a requirement for the boy to receive the pre-school booster, minus the whooping cough element, and to receive the MMR. The nurse asks if the mother is happy for the whooping cough element of the booster to be given, to which she agrees. The nurse then proceeds to give both the pre-school booster and the MMR vaccine. It is only after the mother and child have left the clinic and when the nurse checks the boy’s notes that she discovers that the parents are refusing to let their son have the MMR vaccine.

Case Study 9

The distressed wife of an elderly man who was well known to the practice staff phoned to say she had received a letter inviting him to attend for an over-75 check. Unfortunately, the patient had died 3 weeks earlier.

Case Study 10

An elderly man attended the flu jab clinic. In the hurley-burley of the clinic the practice nurse noticed that he appeared to be a bit short of breath. She asked to him wait until the clinic was finished and then did a proper consultation. The blood test she ordered showed a haemoglobin of 9.3 with Chronic Lymphatic Leukaemia.

APPENDIX 2

NHS Education for Scotland

Significant Event Analysis

STANDARD REPORT FORMAT

Title:

Date of Significant Event:

Date of Event Analysis:

Lead Investigator(s):

1. What happened?

(Describe what actually happened in detail and chronological order. Consider, for instance, how it happened, where it happened, who was involved and what the impact or potential impact was on the patient, the team, organisation and/or others).

2. Why did it happen?

(Describe the main and underlying reasons – both positive and negative – contributing to why the event happened. Consider, for instance, the professionalism of the team, the lack of a system or a failing in a system, lack of knowledge or the complexity and uncertainty associated with the event).

3. What has been learned?

(Demonstrate that reflection and learning have taken place on an individual or team basis and that relevant team members have been involved in the analysis of the event. Consider, for instance: a lack of education & training; the need to follow systems or procedures; the vital importance of team working or effective communication).

4. What has been changed?

(Outline the action(s) agreed and implemented, where this is relevant or feasible. Consider, for instance: if a protocol has been amended, updated or introduced; how was this done and who was involved; how will this change be monitored. It is also good practice to attach any documentary evidence of change e.g. a letter of apology to a patient or a new protocol).

APPENDIX 3 - Illustration of the Glasgow Grid

WHAT HAPPENED AND HOW - WRONG VACCINATION (MMR)

A 3-month old child attended the combined child health surveillance (CHS) and immunisation clinics to receive a 2nd booster of primary immunisation. This was to be carried out by a health visitor (HV) who was newly-trained in immunisation procedures and under the supervision of a more experienced colleague. The HV informed the duty doctor that instead of giving the DTP/Hib vaccine she had wrongly and accidentally administered an MMR vaccine. Both HVs' account of the event was that HV (A) had drawn up the solution from the vial. Only after administering it and checking with HV (B) so that the batch number and expiry date of the vaccine could be recorded in the patient's case records that they both discovered the now empty vial was actually MMR and they realised that HV (A) must have administered MMR to the child instead of the second DTP/Men C booster that was due.

HV (A) informed a general practitioner (GP) immediately of what had happened. The GP explained to the child's guardians that this was a genuine human error and apologised on behalf of all concerned. Understandably the guardians were alarmed that such an error was made especially in the wake of media attention and heightened public anxiety about MMR.

The child's guardians needed much reassurance that their child was going to be alright. The GP also contacted the local hospital paediatric consultant who reassured them that there was no real danger to the health of the child. The GP also visited the child's house later that evening to check on the child and to see how the guardians were coping under the circumstances and to deal with any other concerns they had regarding the wrong vaccine being administered. All staff members involved were also distressed by this event. The potential impact of the event clinically: sore harm/allergic reaction; organisationally: complaint and adverse local media reaction; professionally: embarrassment and distress.

Increasing Depth of Analysis

Superficial → → → → → →→ → → → → → → → → → →→ → → → → → → → → → →→ → → In-Depth

Q1. Why did HV (A) draw up the wrong vaccination?	**Q2.** Why did HV (A) administer the wrong vaccination?	**Q3**. Why did both HVs fail to double-check the vial or inform the guardians prior to vaccination?	**Q4.** Why was there no formal standard immunisation protocol in the practice?	**Q5.** Why did the practice make this assumption?
↓	↓	↓	↓	↓
The MMR vaccine was unknowingly picked up because it was placed next to the DTP/Hib booster vaccine vials on the same work table, which look similar. The HV may have been distracted because the clinic was busy and noisy because the CHS clinic was combined with the vaccination clinic.	The wrong vaccination was administered because HV (A) and HV (B) did not 'double-check' the vial with each other or inform the child's guardians what the vial contained **prior** to administering the vaccine.	There was no formal standard immunisation protocol in place for giving vaccinations.	The practice did not have a protocol in place for immunisation because it was assumed HVs would have been trained to follow a protocol by the PCT.	The HVs are experienced in giving vaccinations and are employed by the PCT. It was assumed that the PCT would have taken responsibility for this. However, responsibility and liability is also an issue for the practice.
Identified Learning Points/Needs				
An over-crowded work space with different injection vials increases the likelihood of error. Combining the clinics increases volume of work, noise and potential for distraction.	The HVs need to be aware of the vital importance in a busy environment of checking the content and expiry dates of vaccinations prior to administration. HVs should confirm with Guardians their understanding of what vaccinations are being given.	The vital importance of having an effective system in a vulnerable area.	Do not assume that adequate training has been provided to attached staff or that staff will always follow standard procedures.	The practice is liable for the safety of their patients.

Change: Identified Action Points

A standard protocol for the immunisation clinic covering each vaccination stage was developed and implemented. A designated immunisation clinic was introduced to provide more time for vaccination and recording. Clearly marked childhood vaccinations were now stored in a designated shelf in the fridge to be brought out for use to a clear working environment.

APPENDIX 4

Title: **Prescribing Error**
Date of Significant Event:
Date of Event Analysis:
Lead Investigator:

1. What happened?

(Describe what actually happened in detail. Consider, for instance, how it happened, where it happened, who was involved and what the impact or potential impact was on the patient, the team, organisation and/or others).

I was the on-call GP for the practice. A member of staff asked me to sign a repeat prescription for a patient unknown to me. As the patient had run out of tablets I was asked to sign the prescription as he was waiting at the reception desk. The script was for Amitriptyline but the dose appeared to be incorrect so I asked for the patient's notes to confirm what the consultant psychiatrist had requested the patient be commenced on. It was then that I noticed that the hand written request had asked for Amisulpiride to be commenced. The patient had a history of psychosis. This was confirmed by checking the consultant's dictated letter. I therefore changed the prescription to the correct dose of Amisulpiride and explained the change to the patient, who was still clinically stable. He accepted the apology after an explanation. However, it does not alter the fact that this patient had been taking the wrong medication for 2-months the potential result that there could have been a recurrence of his psychosis and all that that may have entailed.

2. Why did it happen?

(Describe the main and underlying reasons – both positive and negative – contributing to why the event happened. Consider, for instance, the professionalism of the team, the lack of a system or a failing in a system, lack of knowledge or the complexity and uncertainty associated with the event).

On investigation it transpired:

- A member of staff had misread the medication requested on the hand written note, and had therefore typed the wrong medication into the computer for the acute prescription.
- The script had been presented to the GP without the hand written request from the hospital. It had been a busy time in the practice and he had signed the script assuming it was the correct medication.
- On review of the hand written hospital request by staff involved it could be seen how the mistake had been made due to the poor quality of the doctor's handwriting.

3. What has been learned?

(Demonstrate that reflection and learning have taken place on an individual or team basis and that relevant team members have been involved in the analysis of the event. Consider, for instance: a lack of education & training; the need to follow systems or procedures; the vital importance of team working or effective communication).

- Unfortunately it is a normal expectation for many the handwriting from many doctors to be poor, resulting in poor communication and the potential for serious errors to occur as a result. Caution must always be exercised when reading and interpreting had-written scripts.

- It was made clear to me and the practice team that errors in prescribing can so easily occur if work pressure exists and handwriting is so poor that it can be misinterpreted, particularly by non-clinical staff.
- Safety-nets within the practice structure are needed to prevent this happening again.

4. What has been changed?

(Outline the action(s) agreed and implemented, where this is relevant or feasible. Consider, for instance: if a protocol has been amended, updated or introduced; how was this done and who was involved; how will this change be monitored. It is also good practice to attach any documentary evidence of change e.g. a letter of apology to a patient or a new protocol).

In view of the error a practice meeting was arranged to discuss the significant event. The meeting included members from all the different teams in the practice, and was conducted in a non-confrontational manner. It was made clear how the error had occurred following discussion with the team members, as described above.

Following discussion and team agreement the following changes were introduced to the prescribing procedure within the practice, which the practice manager would lead on:

1. Hand-written requests from the hospital were to be collected by the patient 48-hours after being handed in to reception, unless urgent.
2. All hand written hospital requests were to be presented to the patient's GP, who was then to write the prescription.
3. Staff involved in prescribing were to change their work environment to a quieter room, away from distractions.
4. It was decided that all GPs should sign their prescriptions in their rooms, again away from any distractions.

How can this be prevented from happening again?

It was decided to review the situation with staff at a practice meeting within the next quarter to ensure that the changes had been successfully implemented, and that no similar errors had occurred.

APPENDIX 5 – Feedback Letter

Dr A Smith
GP Principal
Any Medical Practice
Anywhere Close
ANYWHERE

Dear Doctor Smith

SEA Report – Prescribing Error

Thank you very much for submitting your SEA report for educational peer review. I now have the feedback from both reviewers on your audit of this significant event and have summarised this below for your consideration:

- Both reviewers were in full agreement that this was a very important significant event which was worthy of analysis.
- A good description of the event was provided which was clear, concise and easy to follow. The reviewers did comment that it was unclear if the patient was given a 1-month or 2-month supply of the drug initially. If the former was the case then it is possible that the error may in fact have occurred twice before being noticed.
- Both reviewers thought more detail could have been provided in explaining why the event had occurred. For example, providing a clearer picture of the normal system for dealing with hand written hospital outpatient prescriptions would have been helpful. Also, the reviewers thought it unusual for a non-clinician (it would have been helpful to know the occupation at this stage) to be given the responsibility of interpreting a hand-written request, the information from which is then put on the repeat prescription system – a point which you commendably explore in the learning and reflections section of the report.
- In terms of insight demonstrated as a result of the analysis, both reviewers commented that the team had reflected well on the event and identified appropriate learning needs. However, one did raise the continued risk associated with non-clinicians adding/altering prescriptions to the system.
- The actions agreed and implemented by the team were considered by the reviewers to be helpful in terms of reducing the chances of this type of event recurring in future. However, they also made a number of further points for you to consider:

    - It would have been very useful if you had informed and discussed the event with the hospital specialist because of their duty of care to the patient and also to bring the handwriting situation to their attention.
    - How will the new system hold up if the GP is on holiday?
    - What if the patient refuses to wait for 48 hours (or 2 working days?) or if the prescription is considered urgent - what is the practice system in this instance?
    - What system is in place to stop the computer operator inadvertently adding the wrong drug to the repeat prescribing list (i.e. to pick up human error)?

Thank you once again for submitting your SEA report for peer review. I hope the feedback ii useful for this particular SEA and in auditing future significant events.

Yours sincerely

Dr N O Itall
Associate Adviser in CPD