Example Significant Event Audit

Incident report:

Patient (91 years old) admitted to A&E following a fall as lost balance, resulting in a fractured 5th metatarsal with patient unable to be discharged home as unable to cope with reduced mobility. DHx confirmed by Pharmacist using SCR / empty 'Nomad' compliance aid produced by the Pharmacy. Discrepancy noted with MADOPAR (Co-beneldopa) 50mg/12.5mg as TDS on SCR but BD in instructions with compliance aid. Patient has been taking BD.

Contacted GP surgery and Community Pharmacy to investigate which revealed error. Madopar should have been TDS since 28/07/15 (7 weeks ago) when increased by specialist.

Immediate Action Taken to Prevent Further Harm

MADOPAR increased on drug chart to TDS

Results of investigation

28/07/15 Specialist Consultant visited patient at home and advised MADOPAR increase from BD to TDS. Specialist dictates a letter to GP.

30/07/15 GP surgery receives letter from Specialist and a GP records a change to medication but repeat medication list not changed. (Lapse)

04/08/15 Daughter questioned dose of MADOPAR with GP and reassured dose is correct. (Mistake)

13/08/15 Specialist letter actioned by a different GP and repeat medication list updated to MADOPAR TDS but no prescriptions issued. (Mistake)

07/09/15 GP surgery sent Community Pharmacy 4 weekly prescriptions for regular medications for them to dispense in compliance aids and deliver each week. MADOPAR now TDS but not noticed by Community Pharmacy. (lapse)

18/09/15 Patient admitted to LGI A&E following a fall due to loss of balance

Why did it happen?

Review by GP:

The patient was older and vulnerable to harm because of their deteriorating condition **(patient factors)** the theme I keep coming across as a factor is 'brain in neutral' **(Innate 'individual factor': Two system thinking or working on 'auto-pilot').** Doctors generally missing to do the appropriate action as they process scanned letters which is a routine task (Situational factor – routine task). I think this is secondary to the volume **(local working conditions; workload)** and tiredness **(individual factor).** In this particular case I was the doctor who amended the repeat template **but didn't generate a script or task to someone to inform the patient** (**Active failure – lapse**). It was at 8pm after a busy day (**Latent organisational factor – Scheduling. Local Working conditions -workload**).

Lesson learnt

It is human nature to slip into auto-pilot when doing routine tasks, even when they are important and require attention to detail. It is normal to slip into auto-pilot when we are tired (because it is

less tiring). Working on auto-pilot is prone to lapses. The workload necessitates working whilst tired. It will be easier to change the scheduling or distribution of routine tasks, than it will be to overcome human nature.

Action Plan

We're trying to look at workflows to try to mitigate against this. We will try a few different approaches and see what works best. **(Quality improvement methodology)**

Commentary by External Reviewer

This incident is an excellent example of enhanced significant event audit focussing on Human Factors.

Aspects of a good SAE that are demonstrated here are:

- The incident is well described including some patient factors, the degree of harm, the name and dose of the medication involved and difference between what was supposed to happen and what did happen.
- The report includes what was done to rectify the incident for the affected patient.
- The report originated in secondary care and was shared with the GP practice as part of a shared learning culture. It was a statement of fact not a supposition of poor performance.
- The information gathering was sufficiently detailed to tell a story but not cluttered with unnecessary information.
- The review of the information identified the "active failure" (the human error behind the incorrect dose of medicine). It goes on to put this error into context with a range of contributing factors which paints the picture of human beings working hard in difficult circumstances. It recognises the inevitability of human faliability.
- The lesson learnt is described in such a way that it is transferable to other similar tasks (i.e. it is not specific to the prescribing of madopar)
- The actions that are proposed are moderately strong interventions for patient safety. In conjunction with testing some small scale changes to ensure their effectiveness before organisation wide changes are made, the changes to workflow are likely to reduce errors due to "brain in neutral".

The review could have been even better if….

- It had also made reference to the statement in the investigation which said "04/08/15 Daughter questioned dose of MADOPAR with GP and reassured dose is correct". However this could be reviewed in a separate SEA. Such a review would benefit from involving the patient's daughter as a "witness" to the conversation.
- The review had stated how the patient had been informed or included in the SEA as per the Duty of Candour legislation.
- Further benefit may be gained by setting a date when the SEA would be reviewed to see if the lessons learnt have continued to underpin safer practices.