SEA Example.

18th Feb 2013 Incident recorded on Datix:

Patient failed to attend the warfarin clinic twice in November 2012 and they discharged her from their list.
We continued to prescribe the warfarin and the patient didn't have any reviews.
The patient failed to attend all of their routine chronic disease appointments since November and wasn't seen until last week when they were admitted to hospital with an unrelated problem, then it was picked up that they hadn't attended their hospital appointments.

NB patient's INR on admission was 2.4 (Target 2.5; range 2-3)
Patient has AF.

Investigation

Journal entries:

Dec 2011 – Patient suspended after 2 missed appointments
Dec 2011 – Patient contacted and agreed to arrange new INR test.
Feb 2012 - Patient suspended after 2 missed appointments
Feb 2012 – GP letter sent to patient; 'It's important to have these tests done, please make a clinic appointment. Make a GP appointment if you want to discuss'
June 2012 – Called for COPD review
Aug 2012 - Patient suspended after 2 missed appointments
Aug/Sept 2012 – New clinic appointment requested by GP. GP letter sent to patient; "Please make a GP appointment to discuss".
Nov 2012 – Patient terminated for no attendance in 3/12. Re-referral required
Jan 2013 – 2nd letter to call for COPD review.
15th Feb 2013 Discharge to ICT

Pathology:

INR & Dose on 3/10/10, 3/11/11, 10/11/11, 17/11/11, 25/11/11 and 12/1/12 INR 1.7 take 4.5mg od next test scheduled for WC 19/1/12

Prescriptions:

Infrequent prescriptions prior to Aug 2011 then
Warfarin 1mg and 3mg tablets supplied at approx. monthly intervals.

Tasks:

No Tasks

Appointments:

No appointments in this period

In summary:

1. Action was taken following 3 previous letters from the warfarin clinic advising of DNA's and suspension.
2. No action was taken in response to the Warfarin Clinic letter in November advising that the patient was discharged from the service.
3. The November letter was reviewed by a GP on Saturday 24th November 2012 at 19:12.
4. Throughout the period when the patient was not attending the warfarin clinic (from Dec 2011 to Feb 2013) regular prescriptions were being supplied for Warfarin 1mg and 3mg.
5. The patient was having their prescriptions collected by a pharmacy- it is possible the pharmacy was ordering the prescriptions.

Analysis

Comparison of what happened to "best practice" as described by NPSA Alert on oral anticoagulants.

Act of omission by GP on Saturday 24th November 2012 at 19:12.

Act of commission by receptionist issuing monthly prescriptions.

Act of omission by GPs signing monthly warfarin prescriptions.

Act of commission by pharmacist ordering prescriptions.

Act of omission by pharmacist supplying prescriptions.

Were these acts:
Mistakes (knowledge based or rules based errors)
Slips (did the wrong task when trying to do the right task)
Lapses (forgot something or miss-thought something)
Violations (decided to do something different (reasoned or not) (well intended or malicious)

Analysis

Comparison of what happened to “best practice” as described by NPSA Alert on oral anticoagulants.

Act of omission by GP on Saturday 24th November 2012 at 19:12.
A lapse – most likely cause of a lapse is distraction.
At the time the GP hade a 2 month old baby at home.
What was on television at the time?

Act of commission by receptionist issuing monthly prescriptions.
Rules based error: There was no rule or system to prevent warfarin prescriptions being issued if they were still on repeat.

Act of omission by GPs signing monthly warfarin prescriptions.
Knowledge based error. GPs did not know about NPSA guidance. GPs assumed existing systems were safe enough.

Act of commission by pharmacist ordering prescriptions.
Rules based error. There is no guidance on checking INR & Dose when ordering prescription on someone’s behalf.

Act of omission by pharmacist supplying prescriptions.
Reasoned violation. Pharmacist knew that they should check the INR & Dose but thought the GP would not issue prescriptions if the test hadn’t been done.

Contributory factors for the General Practice…..

Action to make patients safer?

Thinking about the contributory factors…

How can we reduce the risk of a doctor getting distracted whilst reviewing letters?

What does the practice need to do to manage warfarin more safety?