

Significant Event Analysis – example for pharmacy practice

What happened

I was one of 3 pharmacists on for the day, 2 retail staff members were also working. I was asked to prioritise a script for Ms G as there was no parking, she had double parked and had left children in the car. I was in the middle of preparing a script for another client and there were 2 other scripts pending. Both of the other pharmacists were involved in counting controlled drugs following a spillage on the bench in the dispensary.

I completed the dispensing process, and informed the retail staff the medicines were ready.

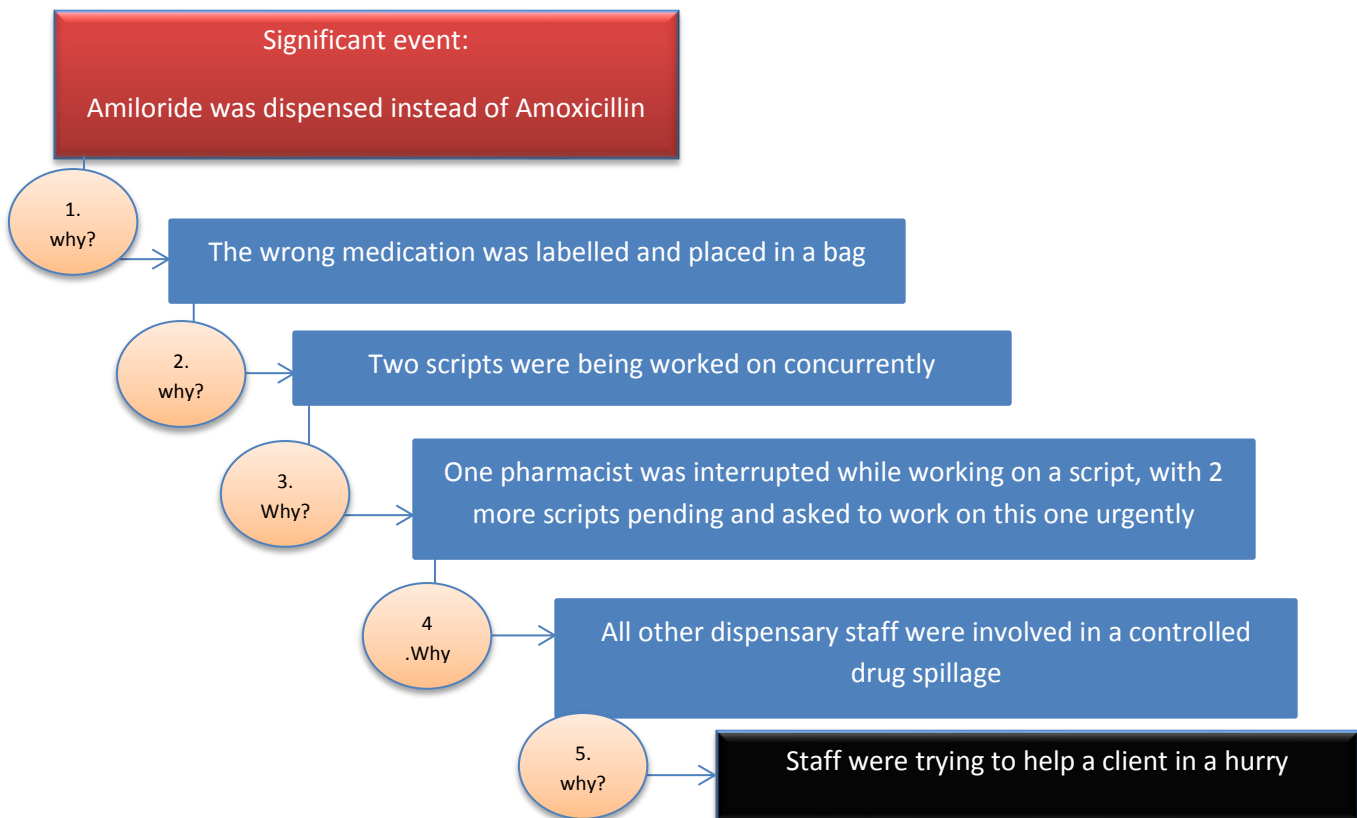
I returned to the script I had been working on before diverting to Ms G's script and realised I had labelled the Amiloride intended for Mr F with the Amoxicillin label for for Ms G's script

A staff member chased Ms G and brought the client and bag of medicines back. I corrected the error, checked all other medicines against the script and explained this to Ms G. This was a very serious near miss as the patient could have had a serious cardiac event.

Why did it happen?

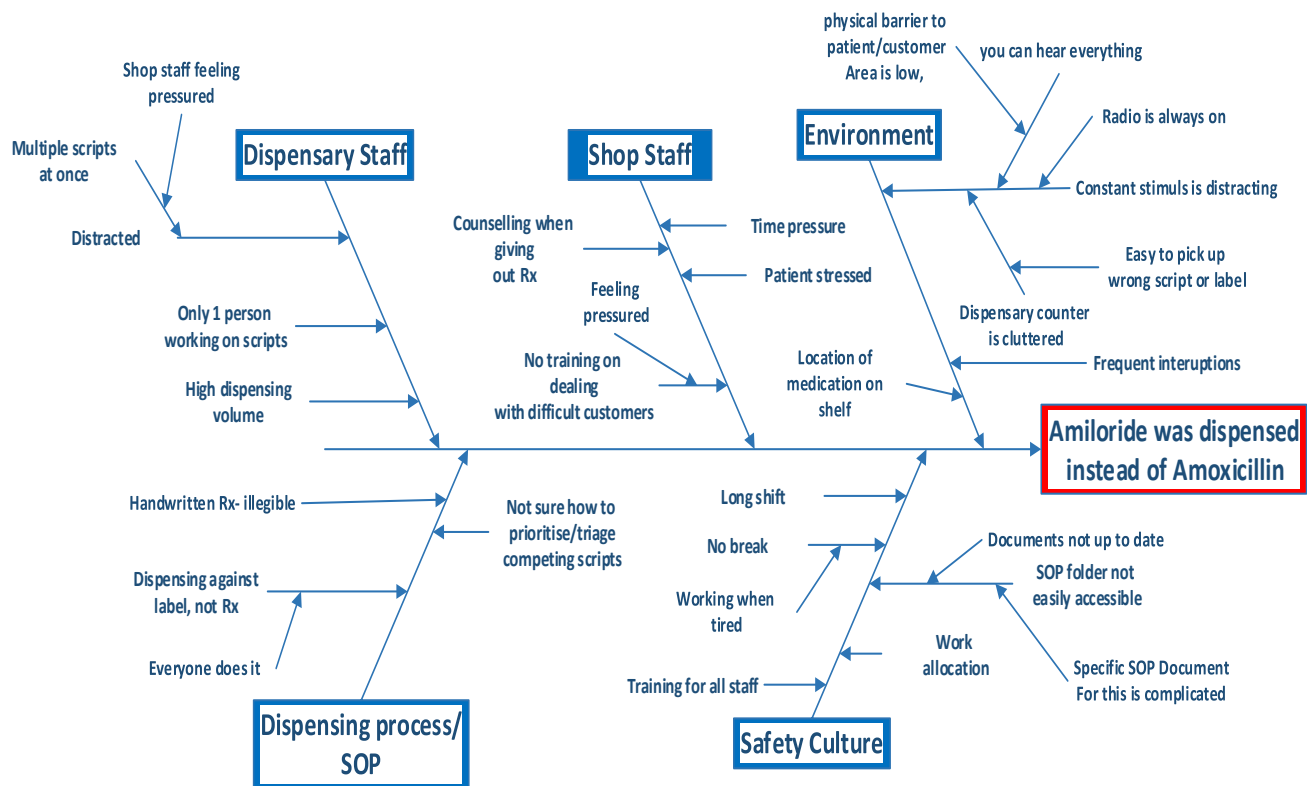
Describe the underlying reasons both positive and negative.

Using the '5 why' enquiry method - It appeared the following took place:



The 5 Whys is one tool to help individuals and teams analyse the causes of incidents understand why an event occurred. The 5 Whys has limitations, for example, identified causes can be influenced by the specific questions being posted and who is asking them; additionally this approach may detect only some of the important contributing factors. If the fifth and final answer does not feel intuitive or 'right' or that it needs 'more', teams may consider using a more in-depth approach by using a Cause and Effect (also known as a fishbone) diagram.

The same problem addressed in the 5 Whys example above is explored below in a Cause and Effect diagram method below



What has been learnt?

- The staff are all very passionate about helping our clients and the dispensary staff don't want the pharmacists to be stressed by urgent scripts
- Our process for how to handle situations when there are multiple conflicting demands on the pharmacists time needs updating; most of the staff didn't know what it said
- Our shop staff feel the brunt of clients who present harassed and demand things are done quickly
- Our dispensary staff need support to be empowered to say 'no' to multiple requests that could compromise safety
- Our policy for safe staffing and safe dispensary volumes was last reviewed 8 years ago and does not reflect current best practice

What has been changed?

Because of this error we had a meeting to discuss the significant event. The meeting was before the shop opened and included every member of the pharmacy and retail staff. We ensured the meeting had ground rules and an agenda known by all staff so there were no surprises. At the meeting we discussed and agreed the following:

- We have reviewed our safe staffing and safe dispensary volumes policy and SOP. The new SOP needs to be trialled in practice
- We have a set dialogue all staff can use when faced with a client in a harassed manner who requests their script be dealt with urgently, so as not to promise something can be done when it might compromise safety
- When the workload in the dispensary is not safe due to competing priorities the lead pharmacist will ask dispensary staff to come together for 2 minutes to agree safe division of work until matter resolved
- Dispensary staff will not stop working mid prescription to start another script until the first one is fully completed
- All staff agree that they need to remain compassionate to the patient's situation but can practice using affirmative language to say something similar to "it is important for safety reasons that the pharmacist prepares one script at a time. We can put your script next, but they need to finish the one they are working on first".

The meeting concluded by reminding all staff that we all make mistakes, safety is everyone's responsibility and if we work together on the actions agreed this type of event will be prevented from happening to anyone else.

How can this be prevented from happening again?

It was agreed that we will review the 5 bullet points in 3 months to see how staff are feeling about using new language with patients and with each other. We need to test our new SOP for how easy it is to read and follow, and the applicability with a locum staff member to ensure it is fit for purpose.