EXAMPLE ONLY

Fellowship Support Program

Significant event analysis template

Please ensure that all patient and practice information is de-identified in your submission.

Identify the incident

26yo man, generally well, no medications. Near-miss case

Brief summary of the incident

Was the patient involved in the incident? Include details of the patient presentation, diagnosis, treatment, and outcome. Include details of any incident that may give rise to a claim for indemnity.

A 26yo man had presented to me for a routine STI screen the week before. He is normally well, no medical history, no medications.

His last STI screen was 6mths previously – 3 female partners, mixed protection, no sex workers since last screen. Most recent partner was 3 wks ago. We discussed appropriate testing, and he was keen to complete a urine chlamydia/ gonorrhoea PCR and declined BBV testing.

His urine result came back positive for Chlamydia, and I recalled him as a quick fit-in telehealth appointment to discuss the result and treatment. I was running late due to a mini-emergency (a patient had a vasovagal faint after blood collection), and had also missed out on lunch unfortunately. I double-checked eTG and gave him an e-script for Doxycycline 100mg BD for 7 days. I asked him to look at the Chlamydia factsheet from Family Planning. We discussed safe sex advice, contact tracing, considering other testing (eg for BBVs which he declined at this stage), and he would return in 3mths for a routine STI screen (and possibly BBV testing then). Earlier review if needed/symptoms developed. I added a recall to the computer software and completed the consultation.

10 minutes later, I received a call from the local Pharmacist alerting me that my patient was actually allergic to Doxycycline! He apparently developed an urticarial rash when another GP elsewhere prescribed it to him for acne. This was not on his medical record. I called the patient, confirmed the allergy (and any other allergies – no he was only allergic to Doxycycline), apologised for the error, and prescribed him Azithromycin 1g STAT as per eTG.

Notification

Who did you notify about the incident? If the patient was involved, how was this communicated to the patient?

I called the patient directly, confirmed the allergy, and apologized for it. I updated his medical record regarding his allergies, to reduce the risk of this mistake happening again. I also discussed this incident with my Supervisor and Practice Manager.

Investigations

What investigations were undertaken by you or the practice in relation to the incident?

I discussed the error at the end of the day with my Supervisor and Practice Manager. My Supervisor checked my documentation (regarding the error, updating the record, and apologizing to the patient). We also did some additional Randomised Case Analyses where the Supervisor would review random cases with me, and purposefully double checked I had also completed the allergy sections for those patients.

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Analysis and action

Outline what processes were undertaken for the review of the incident and what action was generated following the analysis? What were the suggested learning points/actions? Were there any practice changes or policy changes that were implemented following the incident?

We discussed it at the next monthly practice meeting as a learning experience. As a result, it was suggested I complete a clinical audit regarding documentation of allergies in the practice software (I will do this over the next month). There was already a section in the practice policy regarding documentation of allergies.

We also discussed putting in more "catch up" slots in my appointment books to ensure I get a lunch break, and I can accommodate for emergencies better in my schedule.

Reflection

On self-reflection of the incident that occurred, what might have you done differently to avoid such an incident? What might you change in your practice to reduce the risk of an incident from re-occurring?

I do think I was probably doing too much, and am glad that my practice suggested I added more "catch up" slots and "on the day" slots as well. I have also changed my lunch break from 30min to 60min as well.

I also am now more diligent double checking everyone's allergies, and especially before I prescribe anything.

On top of that, my practice software has also been updated to automatically have a pop-up box to double check for any allergies before prescribing (it won't let me prescribe if the allergy box has "none recorded")

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