Implementing Significant Event Management in general practice – potential barriers and solutions

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ABSTRACT

There is increasing international and national focus on error in medicine. Significant Event Management offers a method of error investigation that has a systems focus rather than an individual focus. This research sought to understand the advantages and the potential barriers of implementing Significant Event Management from a practice perspective. Barriers included hierarchical practice structures, practice culture, cost, difficulty with the process and concerns about professional image and litigation. Facilitating factors were considered to be communication in the practice, horizontal practice structures, 'normalising' the process and having an effective external organisation to provide guidance and assistance. There was considerable support for the concept of Significant Event Management in the study practices.

Key words

Peer review, error, health care

(NZFP 2005; 32: 247–250)

Significant Event Management as a method of error control

Significant Event Management (SEM) is a method of investigating error that assumes the majority of error occurs as a result of deficient systems, not deficient people. The SEM process, as described in this paper, was developed by the Royal New Zealand College of General Practitioners, with wide consultation, as a means of learning from significant events in the general practice environment. This principle has widespread recognition internationally and nationally. The New Zealand National Health Committee embraces the systems failure concept of medical error. The committee states, *'There is also a tendency to blame individuals when things go wrong. The National Health Committee believes that problems or failures at a system level are often at the root of errors at an individual level.'*[1]

The second major premise of SEM is that mishaps tend to fall into recurrent patterns regardless of the people involved.[2] Near miss data becomes a valuable indicator of defects in systems and processes as the number of near misses greatly outweighs the number of errors.[3] Recognition of a pattern of error is the key to eliminating the error. Pattern recognition is in turn dependent on systematic reporting of both errors and near misses. The development of a reporting culture in general practice is a prerequisite for successfully implementing a system of SEM. This research is concerned with understanding the difficulties and potential solutions to implementing SEM in the general practice environment.

Method

This research was undertaken in the Waikato. Four medical centres were selected by the research team to ensure large, small, rural and urban practices were represented. The practices were approached and requested to participate in the research. Focus groups were held in all four practices and all practice staff were invited. A total of ten administrative staff (practice managers and receptionists), seven practice nurses and 11 GPs attended the focus groups.

Each meeting began with a summary of the SEM process and a reminder about the research question and aim. Unstructured discussion then followed about the barriers and facilitating factors participants saw to successful implementation of the SEM process. With the agreement of all participants, the meetings were audiotaped.

Using standard qualitative methodology, the focus group audiotapes were transcribed verbatim and reviewed by the researcher to identify themes.[4] The analysis took place in two steps, initial coding and core analysis:

1. **Initial coding.** Potentially relevant text was manually given tentative labels. Initial coding resulted in the generation of 18 barriers and 12 facilitating factors. Quotes exemplifying these themes were identified.
2. **Core analysis.** Initial codes were clustered under three core headings covering both barriers and facilitating factors. The researcher allocated the codes which were then scrutinised by a clinician to confirm they remained relevant from a clinical perspective.

Results

Barriers to implementing Significant Event Management

The barriers raised by the focus group discussions have been grouped under the three headings: the practice environment, the SEM process and external factors.

The practice environment

One of the practices participating in the study believed the imbalance of power within the practice team would pose the greatest barrier to successfully implementing the SEM process. The team felt that the hierarchical structure of their practice created this power differential and therefore the hierarchical structure was responsible for impeding open disclosure and discussion of errors. One GP in this practice believed it would be difficult to alter this imbalance:

'And I do think...despite how we want to neutralise the power base that operates within the practice, we are still the employers of our staff and that will always be a barrier to communicating effectively.' [general practitioner]

A nurse confirmed this:

'I mean in our practice they are the boss so there may be something that we may not want to discuss.' [practice nurse]

For one GP in the current research the power imbalance meant he did not wish to appear incapable in front of staff:

'And I think that's why we don't speak about it is because we have that type of culture. I think that's embedded in the clinical team so that you know the last thing we want to let the nurse in on or a nursing part of the team in on is that doctors make mistakes, as many or more than a nurse.' [general practitioner]

Staff members in two of the practices were mindful of the emotions that are raised when dealing with certain negative events, such as the death of a patient, and were fearful of the emotionally charged meeting and their own emotions. The most commonly raised barrier relating to the practice environment concerned the heavy workload and lack of time that is typical of general practice. Many participants felt their high workload was a barrier with the SEM process presenting as yet another thing to do:

'When I first saw the SEM handout that was sent last year my initial reaction was "bloody hell, not another thing to do" and to a degree I still feel that way even though I can see the value in it.' [general practitioner]

Many GP members in the current focus groups saw the time and energy involved in implementing the process in a busy practice as a barrier. They also felt that lack of time undermined effective communication and contributed to the stress of being in general practice.

Another GP commented:

'Maybe we don't communicate well but it's like we're never given the chance to communicate well because we don't give ourselves the time to communicate well.' [general practitioner]

Two GPs also raised role conflict as a barrier to successful implementation.

'Whenever we come on this sort of level we're interacting both as an employer...and doctor and person. We are friends as well so you have those three levels that we interact.' [general practitioner]

Some participants saw the financial cost of following the SEM process as a barrier. This includes the loss of time through following the process, filling in forms and attending meetings as well as the cost of paying staff to attend meetings. A practice manager explained the financial burden of running a full staff meeting:

'I mean the total bill for having an hour meeting is about $250 minimum here, let alone charge out rate.' [practice manager]

The SEM process

Several barriers were presented that relate to the SEM process itself. One GP felt that they would need to be reminded to complete the process; that remembering to follow the process would present the first barrier. Another GP believed going through the whole process for each incident or event presented a barrier to implementation. The SEM process as it is recommended by the RNZCGP (2002) is for internal use only. One practice nurse questioned the value of the process if the information is not to be passed on to an external body or shared with other practices:

'I think there is no point in doing all this if it is not actually being taken outside the surgery to be looked at by an outsider.' [practice nurse]

As a final process-related barrier, participants raised concerns about their ability to identify and implement solutions to some negative events that may occur. The difficulty of identifying solutions was perceived by many participants to be a potential barrier to successful implementation of the SEM process.

External factors

The third group of barriers raised by focus group members in the current research concerned factors outside of the practice environment. For instance, the fear of tarnishing their professional image was a barrier for some clinical staff. There was a concern that the SEM process would show up the professional as incompetent either to patients or colleagues or through the resulting actions to patients, peer and others. Many clinicians discussed a fear of failure. Some felt that the action required to prevent similar serious events occurring often lies with external organisations, in particular with secondary providers.

'I think it extends far beyond just us here because most of our events that are particularly negative don't involve just us sitting here.' [practice nurse]

Several participants questioned the ability of the SEM process to strengthen their position in the event of an external party, such as the Health and Disability Commissioner, becoming involved. This question raises barriers not only of process but also highlights the fear some members have of litigation and complaint.

Table 1. Results of analysis grouped under the core headings

Key theme	Barriers	Facilitating factors
The Practice Environment	• Hierarchy/power differentials • Fear of emotion • Workload and time • Role conflict • Financial cost • Fear of failure • Lack of skills	• Horizontal culture • Effective leadership • Deal with emotive issues appropriately
The SEM Process	• Lack of solutions • Forget to use process • Lack of definition of a significant event • Lack of confidence in the SEM process • Solutions not shared with other practices • Potential to be GP focused • Initiating the change	• Utilise regular staff meeting • Utilise existing committee • Enter small events into register rather than through whole process • Alternate chair and secretary • Keep SEM forms in the consulting room • Post-it-note on file as reminder • Assign responsibility to follow up SEM process to one staff member • Disseminate SEM information via email
External Factors	• Professional image • Fear of litigation • Third party involvement • Negative publicity	• PHO provide reminders • PHO provide motivation • PHO establish guidelines for definitions • External facilitator • Coordinate sharing solutions

'We have some real fears on that. Is this a discoverable document for someone suing?' [practice manager]

Facilitating factors

The practice environment

Several members saw creating a practice environment conducive to SEM as important. One practice felt they had the right culture to immediately benefit from the implementation of SEM. They attributed a good practice environment to a horizontal structure, which they believe promotes effective communication. When asked what sets their practice apart from others a GP replied:

'...not having a hierarchical structure in a small surgery and having more of a horizontal team approach.' [general practitioner]

Good leadership was also seen by focus group members to promote successful SEM. One practice in the current study felt external facilitation would enhance successful implementation of SEM within their practice:

'I would see [external] facilitation in that sort of potential conflict situation. In part to give the employers a voice other than just their own. Someone that's neutral if you will. And also will, I guess, dissipate some of the anger and defensiveness that can be generated by these sorts of meetings.' [general practitioner]

All four practices involved in the current research were conscious of the highly emotive content of some SEM meetings.

The Significant Event Management process

The second group of suggestions to facilitate the SEM process were those that relate directly to the process itself. Participants in the current study felt it was important the process met the individual needs of the practice. They made the following practical suggestions:

- Keep SEM forms in the consulting rooms
- Use post-it-notes on the patient files to remind staff to follow through with the rest of the process
- Place SEM as a regular item on the full staff meeting agenda rather than establish a separate meeting
- Assign responsibility of the SEM process to one individual staff member
- Keep a record of small incidents in the register but do not put them through the whole process
- Disseminate SEM information via email
- Form a SEM committee, or use an existing committee such as OSH, rather than whole staff.

These suggestions reinforce the value of allowing flexibility of the practical detail of implementing SEM.

External factors

The external factors identified by the focus group members as facilitating successful implementation all related to support from an umbrella organisation. Participants highlighted several areas where they felt such an organisation could be of assistance in promoting successful implementation of SEM:

- Reminding practices to continue using the process
- Providing motivation for continued use
- Establishing guidelines for what defines a significant event
- Coordinating the sharing of ideas and solutions between practices
- Providing external facilitation for SEM discussion meetings.

It is interesting to note that the external factors participants believed would facilitate SEM implementation did not address the barriers that were raised during the focus group meetings. It is possible, for instance, that an umbrella organisation could apply to the Ministry of Health for a Declared Quality Assurance Activity Notice for their review process, on behalf of its member practices, to reduce the risk of litigation.

Limitations of this research

Potential power differentials in the focus groups could not be excluded in terms of their influence on the participants in the research. However, the practice works as a team, whether functional or otherwise. The data for this research was collected from team units and therefore may better echo the beliefs and values of the functional unit. This is both a strength and a weakness of the research.

The transferability of the research to other clinical environments should be treated with some caution. The practices involved in the research belonged to one IPA (organised general practice network) and had been exposed to uniform education concerning clinical governance and significant event management. The beliefs and experiences of practices and practitioners in other organised general practice networks or practices that are unaligned may be different.

Comparison with other studies

An English qualitative study examined the attitudes and perceptions of primary health care workers using the process significant event audit.[5] The conclusions of the study were that significant event audit provided a powerful team building opportunity, better team communication, better mutual understanding and an improved working environment. However, the study also found potential problems with the process that included fear of exposure, concern about causing offence and difficulty stepping out of a hierarchal relationship. There is convincing evidence that confidential systems of reporting are much more acceptable to medical staff than conventional incident monitoring systems.[6]

A further English study emphasized the importance of framing SER as a small group dynamic with all the attendant difficulties that such groups have.[7] These dynamics include hierarchical problems, pre-existing tensions, fear of exposure and fear of litigation. The paper also outlined several potential problems in group dynamics such as collusion, dealing with emotion and inability to recognise deficiencies in care that were common to this study.

Conclusion

General practice teams have areas of concern in how significant event management processes can be practically instituted. Hierarchical internal structures, time constraints and financial costs were the most prominent of these concerns. Effective leadership and a horizontal structure may assist practices to break down these barriers to promote better organisation learning and patient care through SEM. The SEM process must be adaptable to meet the individual needs of practices. External barriers include fear of litigation and negative publicity as well as a perceived inability to effect change when a third party such as a hospital is involved. An umbrella organisation, such as a primary health organisation, may be in a position to assist in the successful implementation of SEM by providing reminders and motivation for practices and coordinating sharing of important SEM information between practices.

Despite a number of barriers recognised by practices, there was strong support for the process of Significant Event Management. That participants identified many ways to improve implementation is of considerable interest and suggests a readiness to adopt change. Further research to prioritise the barriers identified in this study would be beneficial in establishing the extent that the barriers are recognised by other practices.

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References

1. National Health Committee. Safe systems supporting safe care. Wellington: National Health Committee; 2001.
2. Reason J. Human error: Models and management. BMJ 2000; 320(7237): 768–70.
3. Battles JB, Kaplan HS, Van der Schaaf TW, Shea CE. The attributes of medical event-reporting systems: experience with a prototype medical event-reporting system for transfusion medicine. Arch Pathol Lab Med 1998; 122(3): 231–8.
4. Bloor M, Frankland J, Thomas M, Robinson K. Focus groups in social research. London: Sage Publications; 2001.
5. Westcott R, Sweeney G, Stead J. Significant event audit in practice: A preliminary study. Fam Pract 2000; 17(2): 173–9.
6. Weingart SN, Ship AN, Aronson MD. Confidential clinician-reported surveillance of adverse events among medical inpatients. J Gen Intern Med 2000; 15(7): 470–7.
7. Robinson LA, Stacy R, Spencer JA, Bhopal RS. How to do it: Use facilitated case discussions for significant event auditing. BMJ 1995; 311: 315–8.