PORTSMOUTH HealthCare NHS TRUST

Risk Event Form

Can be completed by any member of staff. Use BLOCK CAPITALS and black ball-point pen.

Incomplete or illegible forms will be returned. Shaded box requires Code from page opposite.

Unique Form Serial No : 19084

COPY

A. PERSON AFFECTED (use Continuation Sheet if more than one person involved)

LAST NAME _____ FIRST NAME _____ M / F

DATE OF BIRTH ____/____/____ PERSON STATUS [ ] SERVICE [ ]

PATIENT NO:(if applicable) _____ Staff Only : STAFF GROUP [ ]

NAME OF PATIENT'S CONSULTANT/CLINICIAN _____

B. PROPERTY / EQUIPMENT AFFECTED (Use Continuation Sheet if necessary)

*~~DAMAGE~~ / THEFT / LOSS / ~~FAILURE~~ of/~~to~~ 5 AMPS DIAMORPHINE 5mg (item/s)

* Delete those not applicable

ESTIMATED TOTAL COST OF REPAIR/REPLACEMENT £ _____

Consult Information Services, Estates, NHS Supplies, etc as appropriate

C. WHEN & WHERE

DAY THURS DATE 2/10/03 TIME (24 hour clock) 16.30

WHERE DID THE INCIDENT HAPPEN ? (e.g. name of Trust site + ward/department, patient's home address, details of non-Trust property, etc)

DRUGS MISSING FROM CUPBOARD

LOCATION (e.g. bedroom, bathroom, hall, kitchen, etc)

FERRY HOUSE OFFICE

D. INJURY

NATURE OF INJURY _____

WHERE ON BODY _____ If Staff, was shift completed Y / N

E. WITNESSES & INVOLVED PEOPLE

NAME _____ NAME _____

ADDRESS _____ ADDRESS _____

PERSON STATUS [ ] PERSON STATUS [ ]

F. DETAILS OF THE INCIDENT (Brief description of events. Facts only, not opinion. BLOCK CAPITALS. Use Continuation Sheet only if absolutely necessary)

S.N. FREATHY & EN. OWEN. WENT TO C.D LOCKED CUPBOARD TO GET DIAMORPHINE FOR INJECTION. A DISCREPENCY WAS FOUND BETWEEN STOCK AND DOCUMENTATION OF 5 AMPS OF 5mg DIAMORPHINE HYDROCHLORIDE

G. WHAT HAPPENED IMMEDIATELY AFTER THE INCIDENT (e.g. treatment given, taken to hospital, names of attending clinicians, etc)

BLEEP HOLDER & WARD MANAGER @ INFORMED 3/10/03 Senior Nurse Kim Bezant informed 3/10/03 CD checked by Pharmacy @

H. NAME (IN CAPITALS) OF PERSON REPORTING

S Freathy SFREATHY@owen.nhs.uk DATE 3-10-03.

I. WARD / AREA / DEPARTMENT MANAGER'S ACTION

ACTION TAKEN TO PREVENT RE-OCCURENCE

Increase CD checking to once a week.
No further action taken.

STAFF ACCIDENTS ONLY : Tick to confirm copied to Occ Health & Personnel [ ]

NAME IN CAPITALS D Carlton DATE 3/10/03.

JOB TITLE CN

J. SENIOR / SERVICE MANAGER'S ACTION

SEVERITY CODE M RIDDOR ACTION TAKEN : N/A [✓] YES [ ]

NAME IN CAPITALS L. WEDLAKE DATE 7/10/03

JOB TITLE NURSE SPECIALIST

Top copy to Risk Event Data Entry Clerk (send to Clinical Effectiveness Department, St James Hospital) **via** Department Manager & Senior Manager

Bottom copy stays in book.

East Hampshire NHS
Primary Care Trust

The Department of Medicine for Older People

Critical Incident Review

Date: 21st November 2003

Re: Incident on Jersey House and missing Controlled Drugs from controlled drug cupboard.

Present:

Jane Marshall	Pharmacist (PHT)
Dermot Charlton	Charge Nurse for Jersey House
Eileen Hawkins	Support Services Manager
Lyn Wedlake	Nurse Specialist

Context:

5 ampoules of 5mgs (25mgs in total) of Diamorphine Hydrochloride injections were found missing from the controlled drug cupboard on Jersey House on the 2/10/03. Staff Nurse Freathy and Enrolled Nurse Owen found the discrepancy during a routine check prior to administering prescribed diamorphine injection to a patient.

Senior Nurse cover for St Mary's and Charge Nurse Dermot Charlton were notified on day of event and the Senior person on call manager (Kim Bezzant) plus Pharmacist were notified on the following day (this corresponds with present Medicines policy procedure).

Issues:

The incident has highlighted implications regards safe storage and monitoring on controlled dugs on Jersey House.

1. All controlled drugs are supposed to be checked as correct on a weekly basis but due to increased patient demand this procedure has not been carried out as a priority. However, Dermot Charlton is now making sure that this practice is done weekly.
2. The drug cupboard in question has been reported as inadequate for some time. The cupboard is not big enough to accommodate the amount of drugs needed on the ward. Consequently every time the door of the cupboard is opened some drugs fall out. This problem has also been witnessed by Pharmacist during their checks and highlighted. The problem is now being sorted; a new drug cupboard has been delivered it is just awaiting estates department to fit.

There appears to have been a breakdown in communication as regards following up further action required: (see Medicine Policy; Section 4 paragraph 4.8.1). i.e.

1. A copy of the incident form should have been forwarded to Principal Pharmacist, Operations at SMH or QAH .2
2. As a result the final step in the process was not carried out i.e. The General manger/Divisional Nurse and Pharmacist meet to discuss whether further action is required.

Reflection:

There appears to be confusion over whether the incident should have been reported to the police, but this action is not recorded as a formal action in the Medicine Policy for losses and discrepancies. Maybe this should be clarified within the procedure. However in this particular incident the Pharmacist, Charge Nurse Charlton, or Senior on call Manger did not deem this a necessary action for following reasons:

It is not thought that there was any intentional theft or suspicious circumstances surrounding the drugs in question. It is thought that there are 2 likely reasons for this:

1. Staff checking the Controlled drugs have inadvertently left 1 full box out on the desk after checking and someone else has picked the box up and thrown it in the bin thinking it was an empty box.
2. Staff have taken the last ampoule from a box for administration (all controlled drugs of the same strength are taken from the cupboard at this point and checked for correct amount) they have counted the amount and put back what was thought to be all the sealed boxes but instead have put back the empty box and thrown a full box away. Evidently there was an empty box found in the drug cupboard on one of the routine checks.

Although Jersey Ward staff appreciates that here are valuable lessons to be learned from drug error review/reflections they have felt criminalized as a result of such a major investigation. It was felt that a critical review of this particular incident was excessive but had there been suspicious circumstances for example had it occurred on more than one occasion, then this line of investigation would have been justified. Concerns are that if we continue to scrutinize in such detail errors will no longer be viewed as a learning reflection.

Action Plan:

1. Eileen Hawkins is to arrange for all drug error risk event forms to be copied and sent to Jane Marshall in Pharmacy department. This way there will be two senior people aware that an error has occurred and that an agreement has to be made as to any further action needed.
2. Jersey House has recommenced weekly controlled drug checks.
3. Charge Nurse Charlton has shared the incident with his team and the need to be more vigilant/careful when doing checks.
4. A new larger drug cupboard has been ordered/delivered and is now waiting to be fixed to the wall. Confirmed that this will be fitted on the 24/11/03.
5. The Medicine Policy is currently under review; maybe it could be made clear on what grounds the police need to be notified of a drug incident.

Monitoring:

Lyn Wedlake will be responsible for making sure the actions are carried out.

19084

East Hampshire NHS
Primary Care Trust

DEPARTMENT OF MEDICINE FOR OLDER PEOPLE

CRITICAL INCIDENT – JERSEY HOUSE – 2ND OCTOBER 2003

UPDATE ON ACTION TAKEN

Learning Point	Action Required	Lead	Date	Action Completed
Checking of controlled drugs had not been carried out	Weekly checks to be reinstated	D. Charlton	2.10.04	**Completed** Specialist Nurse Lyn Wedlake confirmed this commenced immediately following the incident
	Audit of weekly checking processes to be carried out on all wards	B. Robinson	31.01.04	**Completed** Specialist Nurses (Lyn Wedlake and Rhondda Cooper) confirmed this system implemented on a two monthly basis at the end of March 2004
Systems need to be in place to ensure all stages of risk events and associated procedures are completed e.g. medicines management	Tighten divisional processes via:			
	Meeting with senior nurses to clarify and agree processes	L. Humphrey E. Hawkins	31.12.03	**Completed** 12th December 2003
	Develop flow chart of actions and responsibilities in managing risk events	L. Humphrey E. Hawkins	31.12.03	**Completed** 14th January 2004

Learning Point	Action Required	Lead	Date	Action Completed
We need to be able to identify staff involvement in any emerging CD drug loss trends	List of staff who had access to the Jersey House CDs in question has been compiled and attached to report A similar list to be prepared in all cases of CD stock loss	Senior Nurses Senior Nurses	12.12.03 On-going	**Completed** Attached to original report On-going
Clarity needed on the issue of police involvement	Clarity to be sought from PCT Pharmacy Adviser	N. Stubbs	31.12.03	**Completed** No definite requirement to notify the Police service. The decision would need to be taken in the light of the scale and / or pattern of any identified loss
Standardized level of stock should be in place	Agreement on standard level of stock to be reached by Ward Staff and Pharmacy	D. Charlton J. Marshall	31.01.04	**Completed** Confirmed verbally by Jane Marshall 26.04.04
Other wards may have similar risks	Learning and action points to be shared with other wards and action taken as appropriate	L. Wedlake R. Cooper	28.02.04	**Completed** Confirmed verbally by Lyn Wedlake and Rhondda Cooper (Specialist Nurses)

Eileen Hawkins
Support Services Manager
Date: 30.04.04

Distribution:

Mrs. L. Humphrey, **General Manager (Elderly Medicine)**
Mrs. S. Lawes, Risk Manager
Mr. D Charlton, Charge Nurse
Mrs. L Wedlake, Specialist Nurse
Mrs. R. Cooper, Specialist Nurse
Mrs. J. Marshall, Senior Pharmacist