FORMAL INCIDENT REVIEW - G.A.W. 20.02.01

Facilitated by J. Diamond

Present all trained nurses - Pat Doe, Elizabeth Milner, Wendy Howell, Jackie Pilcher, Pat Chasi, May Donnachaidh, Jane Wilbourne, Gary Aslett.

This incident review was conducted in respect of a perceived drug error on G.A.W. which was highlighted on 11.02.01 at the 9am medication round.

Staff Nurse Pat Doe found Sulpiride tablets in a foil strip in a box marked Trimethoprim when she was dispensing medication. She immediately removed the box from the trolley and did not give the drug.

She reported this to Deputy Senior Nurse Pat Chasi and together with staff nurse May Donnachaidh they checked the drug recording cards to try and assess if the wrong drug could have been given to the two patients prescribed Trimethoprim. 11 tablets has been used from the Sulpiride foil.

Deputy Senior Nurse Pat Chasi completed a risk event form and informed the duty doctor and the 752 bleep holder, both attended the ward. The duty doctor examined the two patients and could find no ill effects. He advised staff to carry our regular observation and check for side effects. None were noted.

In the preceding four days only two nurses carried out medication rounds where Trimethoprim would have been dispensed these were, staff nurse Jane Wilboune and deputy senior nurse Pat Chasi. These two nurses are both quite certain that the drug dispensed was the correct one (Trimethoprim) as they both state they consistently check foil packs when dispensing any medication. All the staff were sure that these two tablets are quite different in size and a mistake would be easily noticeable.

Jane Wilbourne remembers giving the last Trimethoprim and putting the empty box to one side. She also remembers being exceptionally busy on Saturday night (10.02.01) prior to the incident, with several patients trying to interfere with the trolley during the medicine round and her having to quickly shut the trolley on several occasions to prevent aggressive episodes becoming unmanageable. She believes this is when the Sulpiride could have been accidentally placed in the wrong box.

Actions to prevent a similar event from occurring

1) When returning foil packs to cardboard packets nurses to double check for safety. If in doubt, or hurry leave foil packets out as they all have drug names and dosage on them.

2) HCSW at night will assist the trained nurse during the drug round to help alleviate the interference and distraction caused by restless patients.

3) All regular HCSW will undertake the Trust competency training.

4) Individual drugs for patients are to be ordered, used and discarded appropriately.

The normal procedures of

1) Checking Doctors prescription and signature.

2) Ensuring discontinuation dates are clear and discontinued drugs crossed through with a red pen.

3) Right drug, right dosage, right patient, right time will also continue.

The qualified nurses on G.A.W. will introduce a system whereby they complete a drug assessment by peers on a regular basis.

It was also noted during this review that many of the drug boxes are the same and that this could be a cause for confusion especially for elderly people who have been discharged home and as such I on behalf of the team will be writing to pharmacy to express our concern.

In conclusion this incident appears to have been a one off accident with the Sulpiride tablets placed in the Trimethoprim box during a period of distraction and aggression by patients. It would appear that no patient was given the wrong drug because of the nurses vigilance in checking the foil packets. Therefore no further action need to be taken.