Fareham and Gosport NHS
Primary Care Trust

Notes of 2nd Meeting to Review the Critical Incident Review Action Plan and Root Cause Analysis associated with the Drug Error in Dryad Ward Gosport War Memorial Hospital on Wednesday 22/10/03

Held on 05/01/2004

Present: Caroline Harrington
Justina Jeffs
Jan Peach
Jessie Bell
Charlotte Solway
Rosemary Salmond
Fiona Cameron

ACTION

01/04 Apologies

None.

02/04 Minutes of Previous Meeting/Matters Arising

2.1 Distribution

Fiona confirmed that the Critical Incident Review and Action Plan had been distributed to Nigel McFetridge, Ian Piper, Ian Reid, Dr Gordon Somerville, Andrew Paterson, Kathryn Rowles and Noreen Kickham, Lucy Docherty. A summary of the report and action plan had subsequently been distributed to Portsmouth City PCT, East Hampshire PCT and Clinical Governance and Risk Management Committee members as well as Code A from Hampshire Constabulary. Jan Peach confirmed that the summary and action plan had been shared with the community hospital clinical managers and notes of this meeting would be forwarded to Fiona as evidence for the file. **JP**

It was also agreed that the summary and action plan would also be shared with other service clinical team managers and Jan agreed to ensure this went out on email with copy FC

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ACTION

2.1 CIR Report Management

Trained Admin support has now been agreed for future critical incidents reviews. The issue of taping has been held in abeyance for the time being. It has been agreed that a report will be produced on the day of the critical incident. Caroline Harrington is in the process of setting up a training session on the use of templates to take place prior to the end of January 2004. Following this the training will be come part of general investigators training. In relation to pan PCT root cause analysis training, the NPSA are proposing to provide this, however, it is unlikely to be rolled out to Fareham & Gosport PCT for some considerable time. It was felt therefore, that the PCT should consider whether the complaints manager could develop in-house training. Fiona to discuss with Ann Turner. Those present identified names of individuals they felt would most benefit from initial root cause analysis training: Jan Peach, Rosemary Salmond, Fiona Cameron, Diane Wilson, Jessie Bell and Ann Dalby. FC

3. Action Plan

3.1 Fiona explained to the meeting that Rosemary had undertaken subsequent route cause analysis and used 2 tools and applied them to the critical incident review as a baseline. It was agreed that in process terms it could be done following every critical incident review. General agreement that it needed to be done by a group and was in fact, different from the critical incident review, although the critical incident review is the first step in the process of route cause analysis. Action planning could then take place following both the initial critical incident review to establish time line and the root cause analysis.

3.2 Review of Action Plan

1. A deadline for submission of the spot check data is now mid-January. Rosemary will follow-up with Susan Chad.

2. This has now been achieved with the Flow Chart being displayed on all the wards. RS

- A meeting has been set up for the middle of January to review and formalise the content of the ward induction. This review and new content will be sent to Fiona immediately following that meeting.

- Newly appointed staff will have to complete a drug competency assessment in one week of appointment, and this will be recorded in the individual's personal development portfolio. Annual competency assessments will also be evidenced in individual's personal development portfolio.

		ACTION
	• Jan was able to confirm that the nurses who were involved in this error were deemed to be competent in the administration of ward medication and controlled drugs within the PCT's policy. Evidence of this competency is within the individual's personal development portfolios.	
	• Syringe driver training has taken place and all those who attended have received certificates of attendance.	
	• A mentor has been identified for Nurse R to support her ongoing training and education.	
4.	The spot check associated with this has been undertaken and the syringe driver recording sheet is now being attached to the prescription.	
5.	This is now been achieved and the relevant policies updated to sign post them to one another.	
6.	Agreement was reached that the critical incident review would include a route cause analysis in future. The serious untoward incident/critical incident review action cards have been produced in response to this critical incident review.	
	Action Plan will need to be more specific in the future and specify dates by which achievements can be expected.	
	De-briefing session has been organised for the 22/01/04.	JP
7.	**Other Issues**	
	It was agreed that the responding and reviewing events policy would be altered to include a flow chart outlining the period of time in which reports could be anticipated e.g. Critical Incident Review to take place within 3 working days within the incident.	
	The initial critical incident review report to be produced on the same day.	
	Route Cause Analysis – to take place within 2 weeks of the incident.	
	Final Action Plan – to be produced within 3 weeks of the incident.	
	These guidelines will be amended and appended to the Risk Management Strategy.	CH
8.	**Next steps** – all evidence in relation to action plan to FC by end January.	ALL

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ACTION PLAN

	Issue	Action Required	Person Responsible	Deadline	Evidence
1	Three drug charts in use	Clinical Pharmacist to undertake spot checks on all wards to ensure Drug Chart Guidance is implemented.	SC	mid Jan 04 Ongoing	Reports of findings of spot checks.
2	Failure to alert Senior Nurse/Manager in appropriate way.	All staff to know the correct procedure for reporting critical incidents to Senior Manager in and out of hours.	JP/TS	Dec 03 Achieved	Flow Chart /Action cards to be widely displayed.
3	Inadequate ward induction	A review of the ward induction to clarify/formulise its content. All newly appointed qualified staff to complete assessment of drug competencies within one week of appointment. Established staff should have drug competencies assessed annually. Nurses involved in drug error to complete an intensive drug administration competency pack. Newly appointed qualified staff to receive syringe driver training. Nurse R not confident to ask for help – mentoring system to be implemented for all staff.	JP/TS/CM's TS/CM's TS/CM's TS/HR JP/TS JP/TS	mid Jan 04 Ongoing Ongoing Jan 03 Ongoing Achieved Ongoing	Induction content PDP PDP Complete competencies signed off Company Rep Trainer 12/12/03 Training pack purchased. Mentor identified
4	Syringe driver recording sheet not with prescription chart.	Syringe driver recording sheet to be attached to prescription chart. Documents should be photocopied before being removed from premises.	JP/SC	Dec 03 Achieved	Spot check by Clinical Pharmacist

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5	Nursing staff unclear how to handle performance following error.	All Clinical Policies to give reference to the Performance Management Policy, which will give guidance on actions outside formal procedures.	CS/Personnel Dept	mid Jan 04	Updated policy
6	Other related issues.	Review way the organisation handles issues of this nature in the future. In particular, areas related to staff support and communication with others. A de-briefing session with those involved to be organised.	CIR Action Plan Review Group JP	Dec 03 Jan 04	22/1/04 Notes of Meeting