Fareham and Gosport NHS
Primary Care Groups

NOTES OF A MEETING HELD TO REVIEW THE CRITICAL INCIDENT REVIEW AND ACTION PLAN ASSOCIATED WITH THE DRUG ERROR IN DRYAD WARD AT GOSPORT WAR MEMORIAL HOSPITAL ON WEDNESDAY 22ND OCTOBER 2003 HELD ON 17TH NOVEMBER 2003

PRESENT: Rosemary Salmond
Jan Peach
Justina Jeffs
Caroline Harrington
Jessie Bell
Charlotte Solway
Fiona Cameron (chair)

ACTION

1. **Distribution**

It was agreed that the CIR Action Plan would be distributed to:

Nigel MCFetridge - Strategic Health Authority
Ian Piper - Chief Executive
Ian Reid - Medical Director
Fiona Cameron - Director of Nursing
Dr Gordon Sommerville - PEC Chair
Dr Andrew Paterson - Clinical Governance Lead PEC
Kathryn Knowles and Noreen Kickham - Directors of Public Health those present at the CIR
Neil Stubbs - EH PCT
Lucy Docherty - Chairman.

A summary of the Report and Action Plan would be distributed to:

the Lead for Quality in EH & Portsmouth City - Joe York and Sue D-K **FC/JJ**
Fareham and Gosport PCT Exec Team and Clinical Governance Committee and Risk Management Committee
DC Davis - Hampshire Constabulary.

It was also agreed that the Summary and Action Plan would be shared with Service and Clinical Team Managers across Community Hospitals and District Nursing. **RS/JP**

ACTION

2. **CIR Report Management**

The report has taken some time to be completed, despite the actual review being set up within a week of the incident. It was reported that the main reason was confusion over the format of the report. Whilst guidance is available this had not been used initially. The following actions were agreed to ensure future critical incidents review reports could be produced in a more timely manner.

The following actions were agreed:

- Trained admin support to the critical incident review team. **FC**
- Consideration would be given to taping critical incident review meetings. **ALL**
- The report would be produced on the day of the critical incident review.
- A training session on the use of templates would be set up. **CH**
- Pan PCT Root Cause Analysis Workshop is being developed. **CH**

3. **Action Plan**

It was noted that a number of actions were flagged as being ongoing and all other the deadlines were December 03 / January 04. It was, therefore, agreed that the group would reconvene early in January 04, to ensure sign off of the action plan, which would then be tabled at the Clinical Governance Committee.

4. **SUI Process**

CH reported that following this incident the reporting processes within the PCT had been reviewed. As a result a series of 'action cards' to guide individuals and record actions has been developed.

These will be distributed via line managers and shared with neighbouring PCTs (attached).

5. **Date and Time of the Next Meeting**

The next meeting is to be held on **Monday 5th January 2004 at 11.00** in the Meeting Room at Fareham Reach.

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CRITICAL INCIDENT & SERIOUS UNTOWARD INCIDENT GUIDANCE FOR ALL STAFF – IN & OUT OF HOURS

The table below sets out the procedure for managing the communication aspect of any Critical Incident. Copies of this guidance is kept by the safe haven fax machine at Unit 120, Fareham Reach.

Column C MUST be completed by the person receiving the fax – decisions may be scrutinised post-incident and this form will provide your evidence.

RESPONSIBLE PERSON (Column A)	ACTION – DURING OFFICE HOURS (Column B)	ACTION TAKEN (Column C) Note who you spoke to/what action was agreed and by whom etc.
STEP 1 Member of staff reporting the incident	1. As soon as SERIOUS/CRITICAL incident discovered inform the local manager. 2. Complete an Adverse Event Form *as soon as* possible.	Name of Manager informed: _____ Time informed: _____
STEP 2 Appropriate Local Manager	1. Telephone PCT Headquarters main switchboard (01329 233447) to: a) Alert staff to incoming fax, and b) notify appropriate Director 2. Fax Adverse Event Form directly to PCT Headquarters – to safe haven fax (Unit 120). Ensure fax cover clearly states the **NAME** of the receiving Director. **Fax No: 01329 229446**	Name of Director informed: _____ Time informed: _____

RESPONSIBLE PERSON (Column A)	ACTION – OUT OF HOURS (Column B)	ACTION TAKEN (Column C) Note who you spoke to/what action was agreed and by whom etc.
Member of staff reporting the incident	1. Adverse Event Form completed *as soon as* incident occurs. 2. Report incident to Person in Charge **(COMPLETE COLUMN C)**	Name of Manager informed: _____ Time informed: _____
Person in Charge of Ward/Home/ Premise	1. Report incident to Service Manager on-call **(COMPLETE COLUMN C)**	Name of Manager informed: _____ Time informed: _____
Service Manager on-call	1. Report incident to PCT Director on-call (Mob: 07880 737245; back-up pager 07699 716954): Be prepared to provide as much information as possible about the situation, who has been informed, and what action has already been taken. 2. Fax Adverse Event Form directly to PCT Headquarters – to safe haven fax (Unit 120). Ensure fax cover clearly states the NAME of the receiving Director. **Fax No: 01329 229446** **(COMPLETE COLUMN C)**	Name of Director informed: _____ Time informed: _____

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RESPONSIBLE PERSON	ACTION	ACTION TAKEN Note who you spoke to/what action was agreed and by whom etc.
Any person receiving an Adverse Event Form marked **'CI'**	1. As soon as the completed Adverse Event Form is faxed through to the Safe Haven fax (Fax No: 01329 229446), *hand it* to the named Director (as stated on the fax cover sheet). **Confirm hand-over by completing column C.**	Fax receiver's initials: _____ Named Director's initials: _____ Time of handover: _____

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CRITICAL INCIDENT & SERIOUS UNTOWARD INCIDENT GUIDANCE FOR DIRECTORS (IN & OUT OF OFFICE HOURS)

The table below sets out the procedure for managing the communication aspect of any Critical Incident. Copies of this guidance is kept in a) all Director's on-call packs and b) by the safe haven fax machine at Unit 120, Fareham Reach.

Column C MUST be completed by the Named Director – decisions may be scrutinised post-incident and this form will provide your evidence.

COLUMN A	COLUMN B	COLUMN C
STEP 1 In hours - **Named Director** Out of hours – **Director on-call is 'Named director')**	2. From the information you have been given via conversation with member of staff reporting the incident and the Adverse Event Form, decide whether this incident is a **Critical Incident (CI)** or a **Serious Untoward Incident (SUI)**. The main difference is that a Critical Incident would be contained within the PCT, whereas a SUI is likely to attract media interest (see SUI Guidance issued by HIOW StHA, April 2002, a copy of summary guidance is in every Director's on-call pack). Note: During office hours you should have a faxed copy of the completed adverse Event Form. The form should have been faxed as soon as possible to the Safe Haven fax located in Unit 120. Out of hours information will be via on-call mobile phone, and a copy of the faxed Adverse Event Form should be available the next working day via the Safe Haven fax located in Unit 120.	Time informed of incident: _____ Route to be followed for this incident will be CI or SUI was made based on the following elements:
FOR **SERIOUS UNTOWARD INCIDENTS** GO TO **STEP 3** – SEE OVERLEAF FOR **CRITICAL INCIDENTS** GO TO RECORDING & REVIEWING RISK EVENT POLICY		

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STEP 2 – Named Director	1. **Immediately** VERBALLY inform the Chief Executive, Chair, and on-call Director. Note time of conversation and action agreed with each person. 2. Inform the Strategic Health Authority by telephoning the SUI Hotline: **07977 517637** 3. E-mail all Directors and Chair giving brief details of incident and action taken so far. Remember to note the date and time of the e-mail. **COMPLETE THE TABLE BELOW TO CONFIRM ACTION TAKEN.**

INCIDENT CHECKLIST	**Yes/No**	**Details**
Family informed		
Police involvement		
Media involvement		
Staff involvement		
Patient involvement		

ALERTING ARRANGEMENTS	**Time**	**Action agreed**
1. Chief Executive informed		
2. Chair informed		
3. On-call Director informed		
4. Communications team informed		
5. Strategic Health Authority informed		

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