B|F 5|1|04

Root Cause Analysis of the Serious Untoward Incident that occurred on October 22nd. 2003 in Gosport War Memorial Hospital

What Happened: A prescription Chart was read incorrectly resulting in the sub-cutaneous administration of an incorrect dosage of diamorphine.

How it happened: Human behaviour resulting in a knowledge based mistake from the dispensing nurse and a lapse error from the checking nurse

Why it happened:

1. Patient Factors: End stage palliative care treatment regime using a syringe driver and additional prn doses as required to manage break through pain. Patient became distressed with pain and required additional analgesia.

2. Individual Factors:
Dispensing Nurse
Stress: 3 weeks into new 'E' grade post.
Identified need for support in interview not given priority – mentor not appointed. Induction not specific and not given priority.
Manager had noticed signs of 'not coping'.
Checking Nurse
Stress: Ward very busy

3. Team Factors:
The induction 'super-nummerary' status had been compromised, through a lack of understanding from other colleagues, which lead to assumptions of competence from colleagues and increased expectations of dispensing nurse.
Clinical Manager new in post.
Team adjusting to new leadership.

4. Communication Factors:
Written: 2 charts one for syringe driver and one for prn dose.

5. Task Factors:
None - guidelines up-to-date, accessible and adhered to; access to Senior/specialist advice good.

6. Education and Training factors:
Dispensing Nurse recently appointed. Previously worked in Nursing Home for 12 years; most recent work experience in out patient clinics. No previous NHS ward experience. Limited drug administration experience and in the use of syringe drivers. Recognised in interview that whilst she had a lot of 'transferable skills' she would need a lot of support initially.

7. Equipment and Resource Factors:
None identified relating to this incidence.

8. Working Conditions:

Administrative support to the ward was off sick.
There was a broken bedpan washer.
Ward was otherwise adequately staffed, with appropriate skill mix.

9. Organisational factors:

Culture moving to an open, problem sharing, clinical model, but as a new member in the team this might not have been evident, and so the burden of accountability and responsibility was experienced, leading to stress and a feeling of not coping. The individuals concerned had been surprised at the level of support that had been offered once the incident had been reported.

IDENTIFIED PROBLEM TO BE EXPLORED IS THE 'ASSUMPTION OF COMPETENCE' AND THE CULTURE THAT PERPETUATES THIS.

Pro-active barrier Analysis:

Activity			Target		
Hazard(s)	What Barriers/controls/defences are in place	Failsafe attributes • Strong • Medium • Weak	Improve by?	Cost Implications	Who's responsibility
Assessment of competence on appointment	Only senior staff trained in interviewing skills are involved in the appointment of staff	Weak in this case as not communicated to new clinical manager	Identified specific induction requirements, being noted in appointment letter, which is copied to the line manager.	Nil	Interview panel
Assumption of competence by colleagues	Guidelines, policies and procedures in place, accessible and up to date.	Strong		Nil	
	Administration of controlled drug observed in this instance	Medium - dependent on human behaviour	Specific training and heightened awareness of professional accountability		Senior Nurse and Clinical managers
	Positive validation of an open 'no blame' culture	Weak but developing well	Increase opportunities for reflective practice.		Clinical manager
			Individuals encouraged to ask if don't know.		Clinical manager
			Openly sharing CRI and SUI reviews.		Board, Senior Managers in the PCT.