Fareham and Gosport NHS
Primary Care Groups

CRITICAL INCIDENT REVIEW
DRUG ERROR DRYAD WARD GOSPORT WAR MEMORIAL HOSPITAL
WEDNESDAY 29TH OCTOBER 2003

PRESENT:

Dr D Davis – Staff Grade, GWMH
Betty Woodland, RCN Rep
Susan Chan – Clinical Pharmacist, GWMH
Justina Jeffs – Clinical Governance Manager
Leena Varghese - Staff Nurse Dryad Ward
Helen Russell - Clinical Manager Dryad Ward
Christine Robinson - Staff Nurse Dryad Ward
Toni Scammell - Senior Nurse
Jan Peach - Service Manager
Caroline Harrington - Risk & Litigation Manager

Background to the Incident

The morning was somewhat unusual for the following reasons:

There was a broken bedpan washer
The ward clerk was off sick
Borderline supplements had to be ordered
There was a patient on the ward with unstable blood sugars
Dryad Ward had a full patient capacity of 20 beds

EVENTS TIMESPINE

Day	Time	Speaker	Details	Action
Wed 22/10/2003				
	08.40	DD	I had been on the ward before 9am (8.40ish) to see if all OK and that Mr H comfortable. I saw the family and asked, "Is he OK" – they said, "Yes". I reiterated, if Mr H uncomfortable, they should let someone know as additional analgesia has been written up. I then returned to the day hospital.	
	09.30	DD	CR phoned me in the Day Hospital regarding Mrs O's blood sugar levels and she suggested I should speak to her husband.	
	10.15	CR	Daughter of Mr H approached me as she felt he was getting restless and needed something for his pain. Went to Mr H who was drawing legs up obviously in pain. I had been told on the previous evening that a prn dose of diamorphine was written up should he need it. No dose was mentioned at that point. I then asked LV to come and check controlled drug. I opened drug chart, there was a diamorphine prescription written in left column and assumed that this was the required (prn) dose. When LV came I saw 40mg subcutaneous I did not notice at that point it was for the syringe driver and not for the injection. With hindsight should have realised it was too big a dose. Diamorphine was reconstituted with 1ml sterile water to the 30mg vial and 1ml sterile water to the 10mg vial. LV and I took medication to the bedside checked patient details. The relatives were present. Subcutaneous injection given into abdominal area. We then went back to treatment room to sign for injection. LV said "I think we have made a mistake". LV lifted drug card underneath was another card which stated 5-10mgs diamorphine subcutaneous prn. I froze at this point. I phoned DD who came within 5 minutes to see what had happened. DD phoned HR no response at home. I phoned Staff Nurse LB at home she came in within half an hour. DD went to speak to relatives told them what had happened and what was expected within the next hour. He also told them that there was an antidote, which was probably not advisable due to the patient's condition, and the relatives agreed.	**1** **2**

			LB arrived onto the ward and phoned TS who then contacted JP. I also filled in the Incident Report before everybody arrived. JP and TS advised me and LV to contact RCN or Union reps. JP rang BW. BW contacted me.	**2**
		JP	I asked CR did she not see that the dose written was for a syringe driver and not for injection. CR answered when going through this seemed a lot but not enough to stop.	
		LV	It was a really busy morning – finished the drug round by 09.45.	
	10.20	LV	CR came to ask me to accompany her to administer diamorphine. Checked drug chart together didn't notice '24hr' infusion until after administered. As we came back to the treatment room we then realised it was the 24hr prescription that had been given as the dose. DD talked to family explained error, antidote to reverse but probably not appropriate, relatives agreed. Syringe driver taken down and diamorphine disposed of.	**1**
	10.25	DD	CR called me at the day hospital at that time I was half way through examining patient. CR said that she had given too much diamorphine to Mr H, I went straight to Dryad Ward. Established from CR exactly how much had been given and by what route. CR was in charge of the ward so I thought I'd better get someone else in to take over so she could sort this out. Unable to contact HR so contacted LB as she was due in on a late shift; she came in 20 to 30 minutes later. I saw the family and explained that there had been an error and the dose that should have been given over 24 hours but had been given in one dose. I explained the dose given was quite high and could have an effect on Mr H's breathing to the extent that it may stop although there would be some pain effect. The family told me that since the injection Mr H appeared to be less agitated. I explained that as the dose might suppress breathing an antidote could be given but this could cause him pain by reversing pain control effect. Family didn't want him in pain so refused reversal. I explained that if it did affect breathing this would be over next hour or so. Asked family to keep an eye on him and see what he is like. Only spoke to daughter; son-in-law; grandson. LB came in, TS arrived on the ward. I explained what had been going on and Mr H at that point breathing normal pattern. I remained on ward approximately 1hr after incident and Mr H appeared to be quite stable so returned to day hospital but on bleep should I be needed.	**2**
	11.15	TS	I was contact by LB saying there had been a problem and could I come down. I went to the ward immediately and was told a drug overdose had occurred and DD explained what had happened.	

	11.25	JP	TS contacted me by telephone whilst on Sultan Ward with visitor. Explained to visitor that a situation had occurred and I needed to cut the visit short.	
	11.30	TS	JP and I arrived on ward and spoke to CR and LB to get their side of what happened. We asked them to write statements whilst fresh in their mind and double checked critical incident had been completed.	
	11.30	JP	I met TS in the corridor and we went to Dryad together. Met with CR and LV to ascertain sequence of events and try to reassure the nurses that this would be investigated openly and without blame. CR concerned about future as nurse, which is understandable. I tried to reassure her and look at what had happened. Discussed support and mechanisms open to staff and offered to contact their respective unions. Asked both nurses to write statements, after that asked them to go home as they were quite distressed by then.	
	11.40	TS	I left JP with CR and LV and went to see the family. I explained that I knew about the incident, and knew it was not the appropriate time but asked if they wanted to speak with me at a later date. All said wanted to meet but not at that time, so I told them the ward staff knew how to contact me when they were ready.	**5**
	11.40	JP	I tried to contact JR RCN rep. But he was out for the day and I left a message to contact me. Discussed management of the two nurses with TS to identify remedial actions.	
	11.40	TS	Telephone call from FS (Staff Nurse on in afternoon) asking 2 questions: 1. Had we suspended the nurse? 2. Yes, the family did want to see me and when could they come. I told her that the nurse had not been suspended, but I don't think family were given this answer. They were given my direct number to contact when ready to talk.	
	11.45	TS	I returned to activity room and spoke to CR and LV again to reassure them and collect the incident report.	
	12.00	TS	JP and I returned to JP's office and I completed continuation report of incident form, while JP contacted RS, General Manager to inform her of the incident.	
	12.00	JP	Telephoned RS explained that a drug overdose had occurred on Dryad Ward, that an incident report was being completed and would be faxed to Fareham Reach.	
	12.10	TS	I contacted JC Business Manager Fareham Reach to say that a high-risk incident form was being faxed to Safe Haven and checked with JC that someone would be there and it would be taken to RS.	
	12.20	TS	I contacted JC to confirm that fax had arrived and also contacted the ward to given them contact number should Mr H die.	
	12.30	DD	Returned to Dryad.	

	14.30	DD	I talked again with family and Mr H's breathing was quite stable. Son-in-law said breathing had been more shallow but okay. I said that as 4 hours had gone by we now would have to look for signs of pain.	
	14.45	JP	JR telephoned and I advised him of the incident and requested that he contact CR to offer support. I asked him for the name of the Unison representative for LV. JR said it would be FF who was with him and he would tell her.	
	15.35	DD	I was in the activity room with LB when daughter came and said "I think he is going" I went to his room and he had actually died.	
	15.40	TS	No one had contacted me to say Mr H had died so went to ward as I was thinking that if he hadn't died then now was the time to think about pain relief again. Got to ward and was told that he had just died so I left family to grieve.	
	15.40	JP	TS came to my office to inform me that Mr H had died. I then telephoned RS to advise her of this information.	
	16.16	JP	Whilst in my office TS mentioned the telephone call from Staff Nurse Shaw asking two specific questions (refer 11.40 TS). We discussed whether suspension was appropriate. As we were not punishing them we felt it was important to get all information needed and decide whether CR and LV were a risk to patients. We agreed that in our view that they were not a risk to patients, it was an accident because they had not read the prescription chart correctly. We discussed CR's drug knowledge and agreed that she needed to complete drug competencies. I telephoned RS to inform her that a question had been asked about whether the nurse had been suspended. Discussed thoughts and agreed that suspension was not appropriate but suggested Chris take special leave until the Monday to reflect.	**3** **5**
	16.40	JP	Telephoned CR to see how she was and to inform her that she should take special leave until the Monday. CR agreed to do this and told me that BW had contacted her and would visit the next day.	
	16.45	TS	E-mailed HR to inform her of the incident and stated that CR and LV were not to administer medication or set up syringe drivers unsupervised until they had completed drug competencies. I wished to know if the nurses had mentors and whether CR had had an induction programme as discussed previously. We needed to meet urgently to discuss action plan to ensure this type of incident did not happen again.	**3**
Thursday 23/1/2003				
	09.00	TS	Came to see HR and to arrange some time to sit down and look at competencies for LV and CR. We also spent some time discussing and reflecting on the incident. CR only employed on ward for 3 weeks although had been employed by the PCT prior to this appointment. HR had realised some issues reference to not coping and had tried	**3**

			to meet with her on the Tuesday but didn't actually manage to speak to her because of Mr H's pain. HR had made a note to sit down with CR on Thursday am as Tuesday's meeting had been interrupted. Then came out of meeting and DD asked for me to speak to Dr Q who pointed out that the drug chart had not been signed by CR and to get her to sign it next time she was on duty. RS, General manager, visited the ward to support staff.	
	09.30	DD	Normal routine for Thursday is for ward round with consultant. Dr Q arrived onto the ward and I explained what had happened. I then spoke to Dr J on the phone to discuss what to do next. A joint decision was made to refer case to Coroner. I tried to phone Coroner and was fast bleeped by the day hospital after dealing with that I then spoke to Coroner. I explained Mr H in theory was an expected death but he had received an overdose of diamorphine prior to dying. Now the referral had been made to the Coroner it was out of our hands. Medical notes still on the ward.	
	11.40	TS	DD phoned to say that he had told the family that the Coroner had been informed and that they had asked if we could meet them. He asked me to phone Mrs C (daughter) to arrange a time. Following this I contacted DD to tell him of the time and venue of the meeting.	
	11.45	DD	Contacted by TS to say that family wanted to talk to us and she had arranged a meeting for 12.30.	
	12.30	TS	DD and TS met family and asked if they would like HR involved in the meeting and they said "yes". Contacted HR and she came to the office. Meeting took place with Mr & Mrs C (daughter and son-in-law). Notes of meeting taken. Meeting ended at 1.15pm.	
	14.00	TS	TS sat down with HR and wrote competencies for CR and LV.	
Friday 24/10/03				
	15.45	DD	Contacted by DC Davis saying he was on his way over and could he speak with him. I said I would be here till 5pm. DC Davis said he would be here before then. I agreed to meet them. But then thought there might be a problem. Contacted TS who asked me whether I had a Union rep so someone could sit in with me. I said I hadn't. TS explained she couldn't in case the police wanted to interview her too.	
	15.50	TS	Telephoned Fareham Reach but difficult to get reply due to Staff Conference, eventually spoke to a secretary who got RS to ring me back.	
	16.00	TS	Explained to RS the situation and she said she would sit with DD whilst police interviewed. RS arrived at GWMH approximately 16.30	

	16.31	TS	Contacted DD to tell him that RS had arrived and asked if he would like to come to the office to meet her. He agreed and came to the office. DD told us that he had spoken to Dr J, Lead Consultant Geriatrician, Elderly Medicine earlier but couldn't get hold of him now, so RS went to telephone Elderly Services to ask them if Dr J could contact DD as soon as possible.	
	16.45	TS	Dr J telephoned and spoke to DD and advised him not to speak to the police without a solicitor present. DD returned to the wards and TS left the hospital, leaving RS to wait for the police to arrive. Prior to leaving the hospital TS took Mr H's notes to the Patient Affairs office in case they were needed over the weekend.	
	17.00	TS	RS saw DC Davis and explained that it would be better to interview at a later date when legal representation had been arranged. RS gave DC Davis a contextual statement.	
Saturday 25/10/2003				
		TS	Duty bleep-holder contacted Saturday am as police were requesting Mr H's notes. Senior Nurse AH gave them the notes on Saturday and completed an Incident Form to say notes had been taken.	
Monday 27/10/2003				
	08.45	TS	Informed by Senior Nurse AH that the police had taken Mr H's notes and they would return them Monday afternoon.	
	09.00	TS	Went to meet CR to explain that the meeting had been delayed until 11.00 am as Personnel had to be present. Unfortunately, RCN rep not informed of change of time and couldn't make 11.00 am but was happy for the meeting to go ahead without her. RS contacted TS several times during the morning updating on things that had happened.	**3**
	11.30		HR, CR, CS (Personnel) and myself met to discuss competencies and how CR wanted to take forward her development.	
		CR	I explained that I had worked in nursing home for 12 years before my Outpatients role and that it was similar to the ward role. I had completed a Back to Nursing Course but did not find it terribly informative. As Outpatient work didn't suit me, when an opening came on the ward I felt that I wanted to move back into patient work. Had no experience of how wards are run in the NHS i.e. documentation – routine. I felt I was coming in "green".	
		TS	Discussed CR's experience at the beginning of the meeting, as she needed to be quite clear about this as it was being questioned re suitability for the post. Issues here were about induction to the ward and the role of an E grade. Issues with reference to documentation had been put into the competency plan. CR said that she would prefer to be a D grade and this was discussed more at the meeting as all present felt it	

			was too early for her to make such a decision. CR told us that she had worked evenings in a nursing home for 12 years, had some "experience of syringes drivers but it had been a few years since setting up a syringe driver. She had experience of giving injections in the nursing home and Outpatient Department. Left competencies with CR. Informed her that HR would be her mentor and if there were any problems with the competencies, discuss with HR. Will discuss re-grade in a year.	
		HR	Post meeting: The following courses booked for CR: - AED (defib) - Manual Handling - Communication Skills Course - Fire Course	
		TS	Prior to the meeting FC, Director of Nursing & Clinical Governance had phoned CR on the ward (was looking for BW) to say police will be interviewing her on Thursday. FC had tried about 4 difference times to speak with BW but couldn't, so spoke to CR. TS would have preferred FC going through HR or herself to ensure support.	
	Late PM	TS	Contacted by RS to say police also wanted to speak to LV. So I contacted LV at home to inform her what was happening, and also spoke to FF, Unison rep and explained what had happened. FF said she would speak to LV straight away. DD also contacted by RS saying police wanted to interview him on Tuesday 28th October. Solicitor from Beechcroft Wansboroughs organised to be present. As I was away on Tuesday arranged for BC, Medical Records Manager to meet solicitor.	
Tuesday 28/10/2003				
	15.30	DD	Had police interview, Dr L present as support, and DR solicitor present. Interview ended at 17.30. Police statement being written up and he would be contacted by the police Wednesday pm to sign.	
	17.30	LV	Had police interview, FF and SL, Branch Unison Chair supporting with DR, solicitor present. Police statement being written up and she would be contacted Wednesday pm to sign.	
Thursday 30/10/2003				
	10.00	TS	CR meeting with police under caution. BW accompanying and RCN solicitor present. CR given special leave day.	