FIRST Draft.

Fareham and Gosport NHS
Primary Care Trust

DRUG ERROR DRYAD WARD GOSPORT WAR MEMORIAL HOSPITAL

WEDNESDAY 22nd OCTOBER 2003

Critical Incident Review – Wednesday 29th October 2003

Present:

Dr Dominic Davis Staff Grade, Gosport War Memorial	Helen Russel CM, Dryad Ward, Gosport War Memorial
Betty Woodland, RCN Rep.	Christine Robinson SN, Dryad Ward Gosport War Memorial
Susan Chann, Clinical Pharmacist, Gosport War Memorial	Toni Scammell, Snr Nurse, Gosport War Memorial
Justina Jeffs, Clinical Governance Manager Fareham & Gosport PCT	Jan Peach, Service Manager, Gosport War Memorial
Leena, Varghese, SN, Dryad Ward, Gosport War Memorial	Caroline Harrington, Risk Manager, Fareham & Gosport, PCT

Please note - All times are approximate

Background to the incident

Dryad Ward had a full patient capacity of 20 beds.
A broken bedpan washer
No ward clerk
Had to order border-line supplements
Patient on ward with unstable blood sugars
Three qualified staff on duty

Events Timespine

Time	Spkr	Details
10.15	CR	Daughter of Mr H approached her 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. She 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. She then asked LV to come and check controlled drug. CR opened drug chart, there was a diamorphine prescription written in left column and assumed that this was the prn dose. When LV came saw 40mg subcut did not see at that point it was for syringe driver and not for injection. With hindsight should have realised too big a dose. Diamorphine was reconstituted with 1ml sterile water to the 30mg vial and 1ml sterile water to the 10mg vial. Took to the bedside checked patient, relatives present. Gave injection into adbo area subcut and 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 subcut prn. She froze at this point.

CR phoned DD who came within 5 minutes to say what had happened.

DD phoned HR no response at home.

CR phoned SN Lynne Barrett at home she came in within half an hour.

Dom 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.

Lynne arrived onto the ward and phoned TS who then contacted JP.

CR also filled in Incident Report before everybody arrived.

JP and TS advised CR and LV to contact RCN or Union reps. JP rang BW. BW contacted CR.

JP JP asked CR did she not see that the dose written was for a syringe driver and not injection. CR answered when going through this seemed a lot but not enough to stop.

LV Really busy morning finished drug round by 09.45hrs.

10.20 LV CR came to ask LV 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 24 hr prescription that had been given as the dose. Dom talked to family explained error, antidote to reverse but probably not appropriate, relatives agreed. Syringe driver taken down and diamorphine disposed of.

08.40 DD Had been on ward before 9am (8.40ish) to see if all OK and that Mr H comfortable – saw family and said is he OK – they said yes. Reiterated if uncomfortable, let someone know.

Went to Day Hospital

9.30 Chris phoned about Mrs Osborne and asked to see husband

10.25 Called half way through examining patient at the time CR said that given too much diamorphine to Mr H, came straight over. Established from Chris exactly how much had been given. Chris in charge of ward thought to get someone else in to take over so could sort out. Unable to contact HR contacted Lynne Barrett who came in 20 to 30 minutes. LB contacted as due in on a late shift.

Saw family – explained what had happened that dose in syringe driver should have been given over 24 hours but had been given in one dose. Said dose given quite high and could have effect of stopping breathing but would have some pain effect. They said that since injection had appeared to be less agitated. Explained that as dose might suppress breathing could give antidote but this could cause him pain by reversing effects. Family didn't want him in pain so refused reversal. DD explained that if it did affect breathing would be over next hour or so. Keep an eye on him and see what he is like. Only spoke to daughter; son-in-law; grandson.

Lin Barrett came in, Toni came down. Explained what had been going on and Mr H at that point breathing normal pattern. Remained on ward approximately 1hr after incident and he appeared to be quite stable. Returned to day hospital but on bleep should be needed.

12.30 DD Returned to Dryad.

2.30 DD Discussed again with family. Mr H breathing quite stable. Son-in-Law said breathing had been more shallow but okay. Said as 4 hours would have to look at signs of pain.

3.35 In activity room with LB daughter came and said think he is going. Went there and he had actually died.

11.15 TS Contacted by Lin Barrett saying had been a problem and could she come down. Went to ward immediately and told a drug overdose had occurred. DD explained what had happened.

11.40 Left ward as needed to contact JP

11.30 TS and JP arrived on ward and spoke to Chris and Leena to get their side of what happened. Asked them to write statement whilst fresh in their mind. Double checked critical incident had been completed. Left Jan with Chris and Leena.

11.40 TS went to see the family. Explained she knew about the incident, and knew it was not the appropriate time but asked if they wanted to speak with her at a later date. All said wanted to speak but not at that time. Told them the ward staff knew how to contact her.

11.45 Returned to activity room spoke to CR and LV again to reassure them and collected the incident report.

12.00 JP and TS returned to office and TS completed continuation report of incident form. while JP contacted Rosemary Salmond to inform of incident.

12.10 TS contacted Janice Coombes to say that a high risk incident form was being faxed to Safe Haven – checked with Janice that someone there and it would be taken to Rosemary Salmond.

12.20 TS contacted Janice to confirm that fax had arrived. Also contacted ward to say out of building and give them a contact number should Mr H die.

15.30 No-one had contacted me to say Mr H had died so went to ward as was thinking that if he hadn't died then now was the time to think about pain relief again. Got to ward and told that he had just died – left family to grieve.

11.40 Call from Freda Shaw (SN 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.

Told that no hadn't suspended nurse but don't think family were given this answer. They were given my direct number to contact when ready to talk

16.45 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. Need to meet urgently to discuss action plan to ensure this type of incident did not happen again.

11.25 JP Contacted by TS by telephone whilst on Sultan Ward with visitor. Explained to visitor a situation had occurred and I needed to cut the visit short.

11.40 Met TS in corridor and went to Dryad together.

11.41 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 Tried to reassure and look at what happened. Discussed support and mechanisms open to staff and offered to contact their respective unions. Asked both girls to write statements, after that asked them to go home as quite distressed by then. nurses

12.00 Telephoned Rosemary Salmond and explained that a drug overdose had occurred on Dryad Ward, that an incident report was being completed and would be faxed to Fareham Reach.

11.40 Tried to contact John Rawson RCN rep. He was out for the day but message left to contact me. Discussed management of the two nurses with TS to identify remedial actions.

14.45JP Conversation with JR to advise him of the incident and request that he contacts CR to offer support and asked for name of Unison representative for LV. JR said it would be Fran Fox who was with him and he would tell her.

15.40 TS came to my office to inform me that Mr H had died. Telephoned Rosemary Salmond to advise that Mr H had died.

16.15 Whilst in my office TS received telephone call from the ward from SN Shaw asking two specific questions (as above). TS and JP discussed whether suspension was appropriate. As we were not punishing them felt it was important to get all information needed and decide whether CR and LV were dangerous in their practice. Felt that they were not dangerous, it was an accident because they had not read the prescription chart correctly. Discussed whether CR's drug knowledge was poor and that she needed to complete drug competencies.

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.

16.45 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 JP that BW had contacted her and would visit the next day.

Thursday 23rd October 2003

DD Normal routine for Thursday is for ward round with consultant

9.30 Dr Qureshi arrived onto ward. Explained what had happened. Then spoke to Dr Jarrett on the phone ready to discuss what to do next. Joint decision made to refer case to Coroner. Tried to phone coroner and fast bleeped by the day hospital then

spoke to coroner. Explained Mr H in theory was expected death but had received overdose diamorphine prior to dying. Now referred to coroner out of hands. Notes still on ward.

11.45 Contacted by TS to say that family wanted to talk with us and she had arranged a meeting for 12.30

09.00 TS Came to see HR – sat down as we needed to look at competencies for LV and CR spent sometime discussing and reflecting on the incident.

CR only employed on ward for 3 weeks although has been employed by the PCT prior to this appointment. HR had realised some issues reference not coping and had tried to sit down on the Tuesday but didn't actually speak because of Mr H's pain. HR had made note to sit down with Chris 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 drug chart hadn't been signed by CR and to get her to sign next time she was on duty.

Rosemary Salmond General Manager, visited to support staff.

11.40 DD phoned to say that he had he told the family that the Coroner had been informed and that they had asked if we could meet them. He asked to me to phone Mrs Cullen (daughter) to arrange a time. Contacted DD to tell him of time and venue of meeting.

12.30 Met family asked if they would like HR involved in meeting they said yes. Contacted HR and she came to office. Meeting took place with Mr and Mrs Cullen (daughter and son-in-law) Notes of meeting taken. Meeting ended at 1.15pm

14.00 Sat down with HR and wrote competencies for CR and LV.

Friday 24th October 2003

15.45 DD Contacted by DC Davis saying he was on his way over and could he speak with him. Said could be here till 5 DC Davis said he would be here before then. Agreed 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.

15.50 TS Telephoned Fareham Reach but difficult to get reply due to Staff Conference eventually spoke to a secretary who got Rosemary Salmond to ring me back.

16.00 Explained to RS the situation and she said would sit with Dom whilst police interviewed. RS arrived at GWMH approximately 16.30.

16.31 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 Jarrett earlier but couldn't get hold of him now. RS went to telephone Elderly Services to contact DD as soon as possible.

16.45 Dr Jarrett telephoned and spoke to DD and advised him not to speak to the police without a solicitor present. DD returned to the wards TS left the hospital and RS waited for the police to arrive.

RS saw DC Davis and explained better to interview at later date when legal representation had been arranged.

Prior to leaving the hospital TS took Mr H's notes to the Patient Affairs office in case they were needed over the weekend.

Saturday 25th October 2003

TS Duty bleep-holder contacted Saturday am as police were requesting Mr H's notes. Ann Haste gave them the notes on Sat and completed an Incident Form to say notes had been taken.

Monday 27th October 2003

08.45 TS Informed by Ann Haste that the police had taken Mr H's notes and they would return them Monday afternoon.

09.00 Went to meet CR to explain that the meeting has been delayed until 11.00am as Personnel had to be present. Unfortunately RCN rep not informed of change of time and couldn't make 11.00am 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.

11.30 HR, CR, Charlotte Solway (Personnel) and myself met to discuss competencies and how CR wanted to take forward her development.

CR Explained had worked in nursing home for 12 years before Out Patients appointment and that it was similar to the ward role. Had completed a Back to Nursing Course but not terribly informative. Outpatient work didn't suit so when opening came on ward felt wanted to move back into patient work. Had no experience of how wards are run in the NHS – documentation – routine. Felt she was coming in "green".

TS Discussed CR's experience at beginning of meeting as felt 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.

Chris said would prefer to be a D Grade. 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 nursing home for 12 years, had some experience of syringe drivers but it had been a few years since setting up a syringe driver. Had experience giving injections in the nursing home and Outpatient Department.

Left competencies with CR, HR to be her mentor – if any problems discuss competencies with HR. Will discuss re-grade in a year.

HR Post meeting course below booked for CR

- AED (defib)

- Manual Handling

- Communication skills course

- Fire Course

TS Prior to meeting Fiona Cameron (Director of Nursing & Clinical Governance) had phoned CR on the ward (was looking for BW) to say police will be interviewing her on Thursday. Fiona had tried about 4 different places to speak with Betty but couldn't, so spoke to CR. TS would have preferred FC going through HR or herself to ensure support.

Late pm Contacted by RS to say police also wanted to speak to LV. Contacted LV at home to inform her what was happening. Also spoke to Fran Fox and explained what had happened. Fran said she would speak to LV straight away.

DD also contacted by RS saying police wanted to interview on Tuesday 28th October.

As away on Tuesday arranged for Beverly Carter (Medical Records Manager) to meet solicitor.

Tuesday 28th October 2003

15.30 DD Had police interview, Dr Lord as support, David Roches (solicitor) present. Interview ended at 17.30. Police statement being written up and will be contacted by police Thursday pm to sign.

17.30 LV Had police interview, Fran Fox, Sean Lyon, Branch Unison Chair supporting with David Roches Trust Solicitor present. Police statement being written up and will be contacted Thursday pm to sign.

Thursday 30th October 2003

.10.00 CR meeting with police under caution. BW accompanying, David Roche and RCN Solicitor to be present. CR given special leave day.

ACTION PLAN

Issue	Action Required	Person Responsible	Deadline	Evaluation
Three drug charts in use	Ensure prescription charts are condensed and clearly marked if more than one	SC/DD/TS	Jan 04	
Failure to follow untoward incident reporting process	All staff to know the correct procedure for reporting in and out of hours Cascade to staff	JP/TS CMs	Nov 03 Nov 03	
Concerns about a member of staffs performance that was not passed onto to them.	Ensure staff aware of concerns raised as soon as practical	CM	Immediate	
Drug Competencies not completed	Nurses involved in the drug error to complete an intensive drug administration competency pack All newly appointed qualified staff to complete drug assessment within three weeks of appointment Established staff assessed annually	HR/FS TS/CMs TS/CMs	January 04 Ongoing Ongoing	
Policy of Control and Administration of Medicines by Nursing Staff (CLO6) lacks clarity for a manager handling an error	Section 4.10 needs amending to include actions that a manager could implement.	JJ	January 04	

Newly appointed qualified nurse left in charge of ward in first week	Ensure new member of staff supernumary for first week. Booking of additional staff to ensure correct skill mix on ward if necessary	CMs	Nov 03	
Newly appointed staff unaware of guidelines to follow for non-clinical tasks	Design and produce local guidelines for specific non-clinical tasks	JP/JJ/TS/SC/ward and dept. reps	Feb. 04	
Was the E grade appropriately appointed	Ensure all senior staff attend interview skills training	TS/CMs	Ongoing	Clinical Managers attended
E grade involved lack of awareness of own professional accountability	Professional Accountability section included in competency pack.	HR/CR	Jan04	
Medical Records were incomplete	Locating the missing document Documents should be photocopied before being removed from the premises	JP	immediate	Located and now in medical notes
Breakdown of support mechanism	Ensure that support mechanism for staff used appropriately	JP/TS/CMs/union reps	immediate	
Newly appointed qualified staff not received syringe driver training	Identify funding required to support Company representative visiting wards. Purchase of Training Pack £100 from Trust Funds	JP/TS JP/TS	Dec 03 Nov 03	