Incident One

Incident
The Medicines Management Coordinator discovered that Codeine and Diazepam were missing from the drug cupboard at Gloucester Royal Hospital. The Medicine Administration Record (MAR) sheet was also missing.

Root Causes of Incident

- Changeover of service provider
- Inadequate medicines management training for GPs/ clinical staff prior to go live
- No process for checking codeine and diazepam

Changes to process/Lessons Learnt
A new process for issuing Codeine and Diazepam was introduced. This included:

- Bag with 10 boxes codeine 30mg (28 tablets per box) and 10 boxes diazepam 2mg (28 tablets per box) is provided with MAR chart stating this is correct stock and what the starting tag number in use is. Receptionist and clinician at start of shift open bag together and check that stock matches what it says on MAR chart and that the tag number they broke was the number on the MAR chart

- Both sign on MAR to say stock levels are correct, what they are and the tag number that they are using to close the bag. MAR sheet goes into bag

- Clinician uses stock on shift and signs stock out on MAR and uses FP10PREC (which goes into the CD bag) to record full patient details and records on Adastra.

- At the end of shift receptionist and clinician both sign on MAR to say stock levels are correct based on what was used shown as MAR entries and what stock levels are (similar to recording in controlled drug register) and the tag number that they are using to close the bag. MAR goes into bag which is then tagged.

- This process allows the service to have an audit trail of who has accessed medication, thereby facilitating any investigation. Regular audits are undertaken monthly by the Head of Pharmacy.

Incident Two

Incident

A patient had visited their own GP and been prescribed antibiotics however had been unable to pass urine for 24 hours. The patient called 111 (provided by Care UK) who provided a telephone assessment which resulted in them arranging an appointment for the patient with Stroud Treatment Centre to see an Out of Hours GP. The patient was assessed and the OOH GP arranged for them to be admitted to hospital for follow up care and assessment. The OOH GP noted toward the latter part of the assessment that the patient had lower oxygen saturations than expected however due to other pressures within the treatment centre continued with the plan for referral. The patient returned to the waiting room whereupon they collapsed and was attended to by the staff from the adjacent minor injuries unit. An ambulance was called and the patient was taken to A&E however deteriorated on arrival and passed away in the department. The investigation noted that the patient had an undiagnosed bladder tumour and the decisions by the OOH GP would not have impacted on the patient's outcome. However the Trust will take away learning in relation to the improved implementation planning when acquiring new treatment centres.

Root Cause of Incident

The cause of death was not linked to the care given by the treatment centre however the GP did not review their care plan in order to consider the whole patient clinical picture. If a complete review had taken place the patient would have monitored and placed on oxygen therapy whilst awaiting ambulance transfer. It is likely an undiagnosed bladder tumour was the root cause.

Changes to process/Lessons Learnt

- SWASFT to review information and induction support provided to OOH GPs working for the service.

- GP has reflected that it would have been more appropriate to call 999 and transfer patient to MIU on Oxygen whilst awaiting Ambulance.

- There should be a review of GP support when incidents occur. In this instance the communication around the patient death should have been via the Clinical hub.

- Development of a joint working SOP for integrated working at Stroud TC/MIU.

Incident Three

Incident

On a Friday evening the family of a patient called the NHS 111 service as they were more confused than usual, sleepy and unable to stand. The patient had a complex past medical history and the family were concerned about infection. Following the initial assessment by the Health Advisor (HA) the call was passed to a clinical advisor (CA), who requested a call from the GP out of hours service (OOHs) with a one-hour timeframe. The OOHs service did not respond within the requested time frame.

The family made 4 further calls to the NHS 111 service that evening chasing the OOHs contact. 1 call resulted in another request for a 1 hour OOH GP call back and 2 calls resulted in subsequent calls from 111 staff to the OOH service to chase the delayed GP call back. Following the 5th call from the family to NHS 111, an ambulance response was requested by the clinical advisor.

A paramedic crew from South West Ambulance Service Trust (SWAST) attended, assessed and immediately conveyed the patient to Gloucester Royal Hospital. The patient was admitted to hospital during the early hours of Saturday morning, with a diagnosis of sepsis and transferred to a hospital ward where they sadly passed away on Sunday.

Root Cause of Incident

- Failed recognition of Dx11 as an urgent disposition within the OOHs service due to non-visibility of the 111 case tag in the triage queue.

- Individual Failure to explore the presence of red flags for sepsis

Changes to process/Lessons Learnt

- Patients presenting with sepsis have multiple and complex symptoms which present a challenge in telephone consultations. Clinicians need to ensure they complete a full and careful assessment in order to reach an appropriate management plan and have a low suspicion for sepsis in vulnerable cohorts.
- Human factors such as expectation and confirmation bias may affect clinical decision making and awareness of these issues can improve patient safety.
- Callers who call back repeatedly into the system particularly outside the expected treatment time frame need careful assessment and review. Failure to recognise the significance of past calls into the service can lead to missing important information
- Insufficient clear guidelines and coordination of service time frames can complicate patient case transfers between services.