ACTION PLAN SUMMARY DOCUMENT

Root cause	Actions to address root cause	Level of recommendation Individual (I) Team (T) Directorate (D) Organisation(O)	By whom	By When	Resource Requirements	Evidence of compliance	Sign off
Clinical Pharmacy monitoring not available due to annual leave	TS and SC to work out a process used for obtaining agency pharmacists RS to chase appointment of technician	I	TS/SC	As required	£2/3000 per annum	Cover is provided	RS
Complacency relating professional accountability	Training related to professional accountabili knowledge legal prescription writing, issue with opiates administration and ways to prevent future mistakes.	T			None	Records of attendance at training sessions Drug chart monitoring	BG
Team identity and leadership	Team building event		D	December 2004	£1000	Team roles and accountability more robust	TS
GPs are unfamiliar in the writing of a drug chart	Presentation from SC on things to consider in the writing of legal prescriptions.	O	SC/JP	Autumn 2004	None	Attendance at session	

CIRC.
B/F
① 21/7 ✓ Take to Board
② 12/8 Service Review Meeting
③ then file CIRS CG Drawer

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Complacency relating professional accountability	Training related to professional accountability, knowledge of legal prescription writing, issues with opiates administration and ways to prevent future mistakes.	T	TS/SC	3 training dates have been arranged in June	None	Records of attendance at training sessions Drug chart monitoring	BG
Team identity and leadership	Team building event	T	TS/AD	December 2004	£1000	Team roles and accountability more robust	TS
GPs are unfamiliar in the writing of a drug chart	Presentation from SC on things to consider in the writing of legal prescriptions.	O	SC/JP	Autumn 2004	None	Attendance at session	

Patient Factors

- Elderly, frail, uncertain
- 2 days post op.
- Recently transferred from QAH
- In pain – needing analgesia
- ? able to take medicines as a tablet
- ? mental state/capacity
- ?was patient well known to GP

Individual Factors

GP:

- external distractions

Nurses: (6 involved)

- Over reliance on pharmacist/GP for safe prescribing.
- Complacency re. accountability.

Pharmacist:

- recently returned from leave, discovered error

Task Factors

Administration of drugs:

- ? familiar with this policy
- Is it understandable?

Paracetamol:

- An everyday medication
- Therapeutic dose is ' reasonable' common knowledge

Medicines Administration:

- Is method appropriate?
- Is the process safe?
- Who is responsible for ensuring the medicine is taken?

Prescription Chart:

- Was it legible?
- Was there a continuation sheet?
- How are exceptions highlighted?

Communication Factors

Team:

- How is the handover conducted?
- How much detail is passed on?
- How are exceptions communicated

Prescription Chart:

- 2 medicines containing paracetamol is a complex pain management regime
- Is the prescription clear?
- What determined that the prescribed dose wasn't taken?

Patient:

- How well did she communicate/understand the taking of medicines?.

Blood result:

- What were the paracetamol levels?
- Was there adequate pain management?

Team and Social factors

Clinical Manager is on long term sick.

Do the Nurses consider themselves a team?

There was no cover for the pharmacist whilst she was on leave.

GP Beds:

- There is no formal ward round
- There is no one clinical lead.
- There is no resident doctor.
- There is increased nursing responsibility.
- There are 6 elderly medicine beds with different medical support

Problems to be explored

1. **Use of complex drug regime**
2. **Risks associated with regime not noted.**
3. **Culture of acceptance/non questioning**
4. **Leadership on a GP ward**
5. **Interface between processes in primary care and provider services.**

Education and Training Factors

GP use IT software to write prescriptions n their surgeries – on Sultan they write he prescription on a chart.

Professional accountability is weak.

Methods to use when patient unable to ake tablets is uncertain.

Equipment and Resources

? Availability of non tablet medications.

Working Condition Factors

Interruptions during the Drug/Medicines round.

Interruptions during the Doctors consultation.

Cover when Clinical Pharmacist on A/L

Organisational and strategic Factors

Is there a Clinical Governance structure across Primary and provider services?

Is there 'organisational learning' between provider services and primary care?

How is information particularly relating to policies and procedures cascaded within the PCT?

Are there common standards of practice within the PCT?

Care Delivery Problem

- Failure to delete previous prescription
- Nurses administered excessive paracetamol containing drugs
- The incorrect dose was repeatedly given on 20 occasions
- This is a complicated/risky prescription regime
- 6 nurses were involved – paracetamol administration is a basic protocol
  - What is their core knowledge?
  - How are exceptions highlighted?
- Was this an adoption of the prescription previously determined by staff at PHT?
- Is there a 'blind' belief in the Dr's accountability?
- Is this pure 'human' error?
- Is there an over dependence on the pharmacist?
- Do all qualified professionals accept autonomous professional accountability?
- There is a need for more information regarding the liver function/blood test
  - Was the paracetamol at therapeutic levels?
  - Was there an interaction with other medications?
  - Was the patient receiving enough pain control?

Service Delivery Problem

- Does the culture support a reliance on the Doctor's ability to write a correct script?
- How aware are primary care and provider services of the GWMH 'sensitivity'?
- Perpetuated administration suggests a complacent, unquestioning culture.
- Is there a disengagement with organisational events/learning?
- Does an historic hierarchical structure persist to absolve professional accountability?
- Has an over emphasis of senior organisational support and encouragement post CHI, encouraged a 'we'll be rescued' model of service delivery?

BARRIER ANALYSIS

Type of barrier to be analysed: Human Action

This barrier analysis is applied retrospectively to the incident that was reviewed on April 26th 2004.

TARGET	HAZARD	BARRIERS
Safe administration of drugs containing paracetamol	• Overdosing	Current: Chart monitored by pharmacist
	• Prescribing more than one tablet containing paracetamol in a complex pain management regime	Chart monitored by pharmacist
	• Patient compliance	Recorded in the care plan
	• Drug chart format	Chart monitored by clinical pharmacist
	• Interruptions whilst writing prescription	None
	• Interruptions whilst administrating drug round	None
	• Communication at handover	Handover includes use of nursing notes

PROACTIVE BARRIER ANALYSIS

Activity	Target				
Hazards	**What barriers are in place?**	**Failsafe attributes Strong (S) Weak (W) Medium(M)**	**Improve by**	**Cost Implications**	**Who's responsibility**
Over dosing **Prescribing more than one tablet containing paracetamol in a complex pain management regime** **Drug chart format**	**Chart monitored by clinical pharmacist**	**M**	**Cover for annual leave of clinical pharmacist.** **Appointment of technician** **System to note when there is an area of risk**	**£2/3000.00**	**RS** **RS/JW** **TS/SC**
Interruptions whilst administering drugs	**None**	**W**	**Review skill mix at high GP attendance times to ensure qualified nursing support to GPs**	**TBA**	**TS and Clinical Manager**
Interruptions whilst writing prescription	**None**	**W**			
Communication at handover	**Use of Nursing care plan**	**M**	**Consider also using medical notes and drug chart**	**None**	**TS and Clinical Manager**
Patient Compliance	**Recorded in Drug chart**	**M**	**Should be included in handover and nursing care plan**	**None**	**TS and Clinical Manager**
	What additional barriers are required? **None identified**				