Significant Event Audit

ID: 1 Ref: WEB/9446

Description of incident
Pt noted in 2010 to be clinically in Atrial Fibrillation. ECG not done and no discussion recorded re anticoagulation, though already on aspirin, her CHADS score would have lead to a recommendation of warfarin. Diagnosis not coded so did not go on register.

Immediate Action Taken

Findings of investigation
Pt noted in 2010 to be clinically in Atrial Fibrillation. ECG not done and no discussion recorded re anticoagulation, though already on aspirin, her CHADS score would have lead to a recommendation of warfarin. Diagnosis not coded so did not go on register.

Why did it happen? Contributory factors
Diagnosis missed by a locum GP originally and then picked up by regular GP.AF discovered again on clinical examination in 2014, ECG done and confirmed

Lessons Learned
Discussed with locum GP at next visit.

Action Plan
Discussed in GP meeting and with locum concerned.

Notes

Active Failure
Slip ☐ Lapse ☐ Mistake ☐ Violation ☐

Situational Factors
Task ☐ Patient ☐ Individual ☐ Team ☐

Local Working Conditions
Equipment ☐ Staffing Levels ☐ Workload ☐ Lines of responsibility ☐ Supervision / Leadership ☐

Latent Organisational
Central Functions ☐ Training / Education ☐ Scheduling ☐ Environment ☐ Policy / Procedure / Custom ☐

Latent External
Policy Context ☐ Design of Equipment / Software ☐ Influence of Other Orgs ☐

Culture and Communication
Culture ☐ Internal Comms ☐ External Comms ☐

Quality Markers
Describe Active Failure ☐ Lessons Linked to C.F ☐ AP linked to ☐ HF in AP ☐

tbl_significant_event

Significant Event Audit

ID: 2 Ref: WEB/8673

Description of incident
eDAN received - Gabapentin 300mg tds. Previous prescription for Gabapentin 100mg tds not altered.

Patient on dosette box so Pharmacy alerted us to the error

Immediate Action Taken

Findings of investigation
eDAN received - Gabapentin 300mg tds. Previous prescription for Gabapentin 100mg tds not altered.

Patient on dosette box so Pharmacy alerted us to the error

Why did it happen? Contributory factors
GP error when processing incoming mail09.04.2014Correct strength added and script issued and sent to Pharmacy

Lessons Learned
Discussed at Clinical MeetingThis could happen to anyone. Reminder re informing Pharmacies of changes to medicine dosage

Action Plan
We have fax header template documents for all regular Pharmacies (20+)

Notes

Active Failure
Slip ☐ Lapse ☐ Mistake ☐ Violation ☐

Situational Factors
Task ☐ Patient ☐ Individual ☐ Team ☐

Local Working Conditions
Equipment ☐ Staffing Levels ☐ Workload ☐ Lines of responsibility ☐ Supervision / Leadership ☐

Latent Organisational
Central Functions ☐ Training / Education ☐ Scheduling ☐ Environment ☐ Policy / Procedure / Custom ☐

Latent External
Policy Context ☐ Design of Equipment / Software ☐ Influence of Other Orgs ☐

Culture and Communication
Culture ☐ Internal Comms ☐ External Comms ☐

Quality Markers
Describe Active Failure ☐ Lessons Linked to C.F ☐ AP linked to ☐ HF in AP ☑

Significant Event Audit

ID: 4 Ref: WEB/9369

Description of incident
85 year old lady habituated to lorazepam admitted with diverticulitis and took with her her Dosette containing all tabs, including LorazepamOn discharge the Dosette was not returned with her. She believed her medications had been stopped, felt unwell and GP requested medications reinstating asap. before this could be done she suffered a convulsion

Immediate Action Taken

Findings of investigation
GP reviewed full details of incident with Patient and patients son.Practice partners reviewed findings along with analysis of any practice involvement

Why did it happen? Contributory factors
Hospital dischared patient without dosette box, patient therefore didnt continue with her medication

Lessons Learned
Hospital should review procedures to ensure when patient takes in medication, as they request and are currently running a campaign for, that the patient is discharged in possession of same

Action Plan
In practice all GPs made aware of incident to be aware it may happenThis patient issued with a AUA care plan outlining medication and procedures - GPs aware this may be appropriate for other patientsPractice contact hospital consultant to ask for full invetigationPatients son considering a formal complaint to hospital

Notes

Active Failure
Slip ☐ Lapse ☐ Mistake ☐ Violation ☐

Situational Factors
Task ☐ Patient ☐ Individual ☐ Team ☐

Local Working Conditions
Equipment ☐ Staffing Levels ☐ Workload ☐ Lines of responsibility ☐ Supervision / Leadership ☐

Latent Organisational
Central Functions ☐ Training / Education ☐ Scheduling ☐ Environment ☐ Policy / Procedure / Custom ☐

Latent External
Policy Context ☐ Design of Equipment / Software ☐ Influence of Other Orgs ☐

Culture and Communication
Culture ☐ Internal Comms ☐ External Comms ☐

Quality Markers
Describe Active Failure ☐ Lessons Linked to C.F ☐ AP linked to ☐ HF in AP ☐

Significant Event Audit

ID: 6 Ref: WEB/9763

Description of incident
Pt was requesting prn Co-codamol and also Paracetamol via surgery reception and stockpiling the meds at home. Ended up taking an accidental overdose on 15.1.14 when the large quantities of the drugs were discovered by her daughter.

Immediate Action Taken

Findings of investigation
Attended surgery with her daughter the following week and safeguards were put in place to prevent a repetition.IE-- Alert placed on pt's Home page on Sys1, Pharmacy informed to alert us if any scripts brought in by the patient,Comm Pharmacy technician informed,and daughters decided to supervise her meds.

Why did it happen? Contributory factors

Lessons Learned
To stop allowing receptionists to issue scripts for prn medication.

Action Plan

Notes

Active Failure
Slip ☐ Lapse ☐ Mistake ☐ Violation ☐

Situational Factors
Task ☐ Patient ☐ Individual ☐ Team ☐

Local Working Conditions
Equipment ☐ Staffing Levels ☐ Workload ☐ Lines of responsibility ☐ Supervision / Leadership ☐

Latent Organisational
Central Functions ☐ Training / Education ☐ Scheduling ☐ Environment ☐ Policy / Procedure / Custom ☐

Latent External
Policy Context ☐ Design of Equipment / Software ☐ Influence of Other Orgs ☐

Culture and Communication
Culture ☐ Internal Comms ☐ External Comms ☐

Quality Markers
Describe Active Failure ☐ Lessons Linked to C.F ☐ AP linked to ☐ HF in AP ☐

Navigation Pane

Significant Event Audit

D: 7 Ref: WEB/11411

Description of incident
Patient commenced on Fostair by a GP in January 2014. Pt was on Qvar on repeat at the time.Qvar not stommed and pt prescribed bot inhalets x 3 times during the past year. Pt has poor compliance with her inhalers

Immediate Action Taken

Findings of investigation
Pt commenced on Fostair by a GP. Qvar not stopped. Pt received ppt for both x 3 times during the year. Poor compliance.

Why did it happen? Contributory factors
Poor attention to mediation detail

Lessons Learned
Sharing the incident, which highlights the ease with which adverse med incidents occur.

Action Plan
More care in issuing ppts

Notes

Active Failure
Slip ☐ Lapse ☐ Mistake ☐ Violation ☐

Situational Factors
Task ☐ Patient ☐ Individual ☐ Team ☐

Local Working Conditions
Equipment ☐ Staffing Levels ☐ Workload ☐ Lines of responsibility ☐ Supervision / Leadership ☐

Latent Organisational
Central Functions ☐ Training / Education ☐ Scheduling ☐ Environment ☐ Policy / Procedure / Custom ☐

Latent External
Policy Context ☐ Design of Equipment / Software ☐ Influence of Other Orgs ☐

Culture and Communication
Culture ☐ Internal Comms ☐ External Comms ☐

Quality Markers
Describe Active Failure ☐ Lessons Linked to C.F ☐ AP linked to ☐ HF in AP ☐

tbl_significant_event

Significant Event Audit

ID: 10 Ref: WEB/8693

Description of incident: INR result came down link for pt against a different NHS number. Was matched up to wrong patient. GP filing result did not notice that pt not on warfarin.

Immediate Action Taken:

Findings of investigation: INR result came down link for patient similar name and was matched to wrong a patient of ours when she was registered elsewhere.GP did not notice not on warfarin and filed

Why did it happen? Contributory factors: Warfarin clinic put wrong bar code sticker on it.Sec matched up to wrong patient.

Lessons Learned: Take more care when matching up check at least 2 data pieces.

Action Plan: Write to warfarin clinicInvestigate who match it up and discuss with them.

Notes:

Active Failure
- Slip ☐
- Lapse ☐
- Mistake ☐
- Violation ☐

Situational Factors
- Task ☐
- Patient ☐
- Individual ☐
- Team ☐

Local Working Conditions
- Equipment ☐
- Staffing Levels ☐
- Workload ☐
- Lines of responsibility ☐
- Supervision / Leadership ☐

Latent Organisational
- Central Functions ☐
- Training / Education ☐
- Scheduling ☐
- Environment ☐
- Policy / Procedure / Custom ☐

Latent External
- Policy Context ☐
- Design of Equipment / Software ☐
- Influence of Other Orgs ☐

Culture and Communication
- Culture ☐
- Internal Comms ☐
- External Comms ☐

Quality Markers
- Describe Active Failure ☐
- Lessons Linked to C.F ☐
- AP linked to ☐
- HF in AP ☐

Significant Event Audit

ID: 12 Ref: WEB/8711

Description of incident
Patient on MTX, given trimethoprim for UTI. Both folate antagonists.

Immediate Action Taken

Findings of investigation
An alert is on the system but this was not seen.

Why did it happen? Contributory factors
Although there is an alert on the system it is not a major alert and is easily overridden.

Lessons Learned
Feedback to Systmone that alerts need to be made more prominent.

Action Plan
Path lab contacted to discuss options but very limited. Advised to stop MXT while patient is on antibiotics.

Notes

Active Failure
Slip ☐ Lapse ☐ Mistake ☐ Violation ☐

Situational Factors
Task ☐ Patient ☐ Individual ☐ Team ☐

Local Working Conditions
Equipment ☐ Staffing Levels ☐ Workload ☐ Lines of responsibility ☐ Supervision / Leadership ☐

Latent Organisational
Central Functions ☐ Training / Education ☐ Scheduling ☐ Environment ☐ Policy / Procedure / Custom ☐

Latent External
Policy Context ☐ Design of Equipment / Software ☐ Influence of Other Orgs ☐

Culture and Communication
Culture ☐ Internal Comms ☐ External Comms ☐

Quality Markers
Describe Active Failure ☐ Lessons Linked to C.F ☐ AP linked to ☐ HF in AP ☐

Significant Event Audit

ID: 13 Ref: WEB/9240

Description of incident
Pt prescribed verapamil 120mg tds instead of verapamil MR 120mg od (as per TAN). Receptionist added on incorrect dose and formulation of verapamil. Duty doctor then signed for wrong dose - didn't check prescription against TAN. Pt took wrong strength for 4/52. Reported ankle oedema so pt stopped taking verapamil.

Immediate Action Taken

Findings of investigation

Why did it happen? Contributory factors

Lessons Learned
Pharmacist discussed with Reception - great care needed when adding meds from TANs - if in doubt forward to GP. Clinicians need to be more careful when signing prescriptions. Safety net in place - pharmacist checks all TANs added by Reception within 1/52.

Action Plan

Notes

Active Failure
- Slip ☐
- Lapse ☐
- Mistake ☐
- Violation ☐

Situational Factors
- Task ☐
- Patient ☐
- Individual ☐
- Team ☐

Local Working Conditions
- Equipment ☐
- Staffing Levels ☐
- Workload ☐
- Lines of responsibility ☐
- Supervision / Leadership ☐

Latent Organisational
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- Environment ☐
- Policy / Procedure / Custom ☐

Latent External
- Policy Context ☐
- Design of Equipment / Software ☐
- Influence of Other Orgs ☐

Culture and Communication
- Culture ☐
- Internal Comms ☐
- External Comms ☐

Quality Markers
- Describe Active Failure ☐
- Lessons Linked to C.F ☐
- AP linked to ☐
- HF in AP ☐