TRUST BOARD IN PUBLIC	Date: 19th December 2013 Agenda Item: 2.1
REPORT TITLE:	A Patient story ï Never Event
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REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	

Purpose of the Report and Action Required:		**(√)**
	Approval	
	Discussion	*
	Information/Assurance	

Summary: (Key Issues)

A great deal of effort has gone in to the safe and appropriate prescribing of antibiotics in the trust. However in this case prescribing and drug administration contributed to a patient receiving a cytotoxic medication on consecutive days, a patient safety ñnever eventò This presentation discusses how this occurred and lessons learned.

Relationship to Trust Corporate Objectives & Assurance Framework:

To deliver a safe, high quality service.

Duty of candour

Corporate Impact Assessment:	
Legal and regulatory implications	
Financial implications	
Patient Experience/Engagement	
Risk & Performance Management	As discussed at relevant divisional and management boards, and reported externally
NHS Constitution/Equality & Diversity/Communication	

Attachments:

Appendix é .

Patient story

An 87 year old female patient with a complex history of rheumatological, cardiac and diabetic illness was admitted with deteriorating health. On admission, she was regularly receiving 13 medications. An initial diagnosis of urinary infection was made and antibiotics were commenced. The patient's condition worsened with evidence of increasing chest infection and additional appropriate antibiotics were given. She developed signs of abdominal obstruction and was reviewed by the consultant and managed with restricted intake and a naso-gastric tube. She continued to show a mixed picture of vomiting with abdominal distension, but with occasional bowel opening.

Having been admitted for approximately three weeks, her drug prescription chart was re-written by the FY1 member of the team. A junior pharmacist reviewing medication and prescribing on the ward noticed that one of the medications, methotrexate (a cytotoxic drug) had been prescribed as a weekly dose but had been given on two consecutive days. This was immediately escalated to the pharmacy manager and to nursing and medical staff. Despite initial stabilising and improvements, she subsequently re-deteriorated.

She was again reviewed by relevant medical teams, including the ICU outreach team who did not feel that admission to the ICU environment would be appropriate, and three days later the patient died with cause of death as aspiration pneumonia (1a) and bowel obstruction (1b).

Contributing factors

8 days before the patient died the drug chart was re-written as the administration section had become full. Methotrexate cannot be prescribed by an FY1 so it has been written but not signed. The SHO (an experienced locum) signed and dated the drug, wrote his GMC number and correctly added weekly in the special instructions box. He drew a box around the next days date to indicate the drug should be given. The next day the nurse discussed giving the drug with the patient who initially refused as it was not the day of the week on which she normally received the medication. The nurse coded the refusal and discussed this with the doctor who suggested as it had not been given the previous week it should be given. This was accepted by the patient who received the drug and the nurse crossed out the code for non-administration and signed it had been given.

The following day another nurse performed the morning ward round and again gave 10mg methotrexate. The pharmacist spotted this on the same day and crossed through the next 6 days on the drug chart to prevent any further administration in the days that followed.

All nurses involved had completed their statutory and mandatory training in relation to drug administration. Crossing out 6/7 days on a drug chart for a weekly prescription when prescribing is not part of the medicines management policy (MMP) at SaSH, but it is considered to be good practice within the NPSA alert (13) on prescribing methotrexate.

Lessons learned and changes made

The prescribing and administration instructions and history were confusing and possibly because the drug chart was long, corrections were made rather than re-transcribing the chart. This led to confusion on both the first and second day of administration.

The MMP did not reflect best practice for prescribing methotrexate (and other weekly medications) by mandating crossing through days when the medication should not be given (now being corrected).

The pharmacist had a number of wards to review and did not review the chart on the day it was re-written, missing a possible opportunity to spot the possible safety threat before the event (business case for improved staffing by ward pharmacists and increase to 7 day working being written).

There is no central mechanism to prevent consecutive day dispensing of the cytotoxic for the same patient (being considered separate from the electronic prescribing project).

NB: ward staffing levels were appropriate over both the days on which methotrexate was administered.

Conclusion

The administration of methotrexate, a cytotoxic drug, on consecutive days is a never event.

In this patient the investigation revealed a principle fault in the safety of the prescription, from which the consecutive administration was possible, though a number of other system checks that might have prevented the second dose from being given did not function.

This serious incident remains open with the CCG and we are discussing their wish to re-categorize as an administration error, as logically both prescription and administration contributed to the patient receiving two doses in 24 hours. The total dose did not exceed the single dose given to many patients and has not been deemed as contributory to the death of the patient.

Des Holden Medical Director
16.12.2013