When you raise a Quality Alert, you are supporting changes in patient safety for the residents of South East London

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'You Said – We did'

Some key vignettes, Lessons learned from Quality alerts and Incidents

July 2021 Edition

Several GP practices raised a concern on behalf of a number of patients who had reported long waiting times when trying to book phlebotomy appointments provided by the local NHS Trust. After a considerable wait, the telephone line will cut off and requests for call backs were not being followed up. This issue was raised on social media with several patients reporting that they had resorted to having to pay for blood tests at local pharmacies in order to get their bloods taken.

This alert has enabled the following lessons and actions to be identified by the Trust:

- Patients were contacted by the Outpatients Manager at the local hospital and confirmed they had had their blood test appointments.
- The significant rise in demand for blood testing since the easing of the last lockdown has resulted in a significant increase in calls to the phlebotomy contact centre and the challenges with access to blood testing were recognised by the CCG and the Trust, who are working in partnership to improve access to the telephone booking line and reduce waiting times. This work has increased capacity for residents by 10% over the last four weeks, with more additional capacity in the next few weeks.
- Work is ongoing to improve the responsiveness of the telephone line and an online booking solution is in development to enable patients to book their appointments directly.

Patient was admitted to a local hospital with constipation and urinary retention. Also reporting drowsiness in recent days at home. Patient was being treated for biliary sepsis with IVABX.

Patient was dispensed/prescribed high concentration Oxycodone IR liquid 10mg/ml and instructed (label on bottle) to take **2.5-5ml** every 2-4 hours PRN. Patient had his bottle of oxycodone with him on admission (locked in CD cupboard). Recommendation was for patient to have **2.5mg** IR oxycodone every 2-4 hours PRN for pain.

This was noticed on hospital admission when patient was confused as to why he was being given such a small dose compared to what he had been taking at home. Patient had been keeping a diary of his PRN use, so hospital staff were able to see that he had been taking approximately 100-125mg IR oxycodone every 24 hours for the last 5 days. Patient had become opioid toxic with oxycodone.

This alert has enabled the following lessons and actions to be identified by the pharmacy and GP practice:

- The error occurred at the time of dispensing the medication by the local pharmacy, where the prescribed dose was converted to millilitres. The pharmacy was made aware of this error and have agreed to carry out a root cause analysis to prevent this from happening again.
- A significant event review was held by the GP practice and agreed to implement a double-checking process to minimise any risk of errors and will be discussing this further with the wider clinical team. Practice will also follow this up with a duty of candour conversation with the patient.

Your quality alerts are appreciated and support system wide learning and patient safety which can lead to improvements in quality in the care of our residents. Report your Quality alert here