

Deck 2

Investigation A

Introduction

An **investigator** has been selected to find out more about the incident described in the **Datix Report** (which you have just arranged on the timeline).

On the next card you will be introduced to this investigator and follow them as they use different methods to learn more about what happened.

 **Draw the next card**

When you have completed the inside of this card, **shuffle the remaining cards in this deck, then draw 10 of them.** These will be your **investigation cards.**

These cards show the types of information that might be found during the investigation. Read each card and place it on the timeline to add more detail to the event. →

→ When 10 yellow cards have been placed on the mat, the investigator's time and resources have been used up and the investigation must end. **The leftover cards show that some information never comes to light.**

Go to **page 3 of the Activity Booklet** to record your thoughts so far.

Investigator A

First complete the **inside** of this card to learn more about who this investigator is.

Then follow the remaining instructions to learn how to complete this investigation phase.



Open this card

Investigator A



This healthcare professional may have been chosen to be an investigator for this incident because some part of the incident aligns with her expertise.

Day Job

“Investigator” is not her day job, she is asked to do this in addition to her existing healthcare role:

From the stickers included in your kit, choose a **day job** and **stick it here**.

Commitments

Due to other commitments both inside and outside of work she cannot give this investigation all her focus and attention.

From the stickers included in your kit, choose a **commitment** and **stick it here**.

Deck 2

Investigation A

3

Patient's Son

Email

...I said no to a group meeting. I'd prefer an informal chat. **I don't like the idea of sitting across from a load of senior staff talking their jargon.** I don't even know what they expected from me...

Deck 2

Investigation A

4

Patient's Son

Phonecall

...Thanks for calling, it's been a rough time so it's good to feel like someone's actually listening. **I appreciate the chance to share my thoughts on what we can learn from all this...**

Deck 2

Investigation A

5

Patient's Son



Phonecall

<< voicemail >>

Thanks for your call.
During the week I work
**in remote rural areas
with very little signal.**
Please leave a
message and I will
contact you as soon as
I can.

Deck 2

Investigation A

6

Patient's Son

Phonecall

...I get that mistakes happen. That overdose of morphine, which I'm led to believe was a small one, was apparently spotted quickly. **Why couldn't they make sure that mum was safe and comfortable in bed?...**

Deck 2

Investigation A

7

Nurse

Email

...I'm sorry but I can't recall what this investigation process entails? **I read a stack of documentation from the trust when I started, but that was years ago...**

Deck 2

Investigation A

8

Nurse

Email

...I didn't get support from the matron to prepare my account of that night. She's very formal and very good at her job, but we don't really have a "friendly" relationship...

Deck 2

Investigation A

Nurse

Email

...It was only me and the matron who were around on the night shift, **that's not uncommon, there's never been a huge amount of staff at night...**

Deck 2

Investigation A

10

Nurse

Email

... I can't tell you why I didn't double-check the dosage. **I now know that the pharmacist raised a query that the dosage might be too high**, but it was just another notification on the system. There's so many that they often slip through the net...

Deck 2

Investigation A



Conversation

... After the suspected morphine overdose the patient was made as comfortable as possible, **But it was a busy shift, with only two of us on the ward and a lot of patients who needed attention...**

Deck 2

Investigation A

12



Conversation

I'm not sure how it happened. The pharmacist prepares the dosage and the nurse double-checks it. **I have to say the nurse didn't hesitate to call attention to the error and took steps to ensure the safety of his patient.**

Deck 2

Investigation A

13



Conversation

... It is entirely possible that **even a slight overdose of morphine could cause confusion** and may explain why she tried to get out of bed in the first place...

Deck 2

Investigation A

14



Conversation

...The nurse and myself never made time to talk about it at the end of the night. I do regret that. **I think I had my 'damage control' head on and just focused on the immediate steps I needed to take...**

Deck 2

Investigation A

15

Investigator's notes



Clinical Records

After her fall, the **patient** discussed the risks of the hip operation with an Anesthetist, with her **son** present. After the discussion she eventually agreed and gave her consent.

Deck 2

Investigation A

16

Investigator's notes



Clinical Records

The **pharmacist** provided a **dispensing note** with the morphine which highlighted that the requested dose was higher than normal for a patient of this profile (age, weight etc.)

Deck 2

Investigation A

17

Investigator's notes



Clinical Records

There was **no evidence of a falls risk assessment** undertaken when the **patient** was admitted.

Deck 2

Investigation A

18

Investigator's notes

RE: Patient Contact

The patient is bed-bound, recovering from surgery. **The family think a phone conversation will cause her more distress.**

At this time she is unable to provide any further information.

Deck 2

Investigation A

19

Investigator's notes



RE: Medication Responsibilities

The **nurse** thinks that the pharmacist must have prepared the wrong dosage of morphine.

The **pharmacist** indicates that it is the nurse's responsibility to double check this.

Deck 2

Investigation A

20

Investigator's notes



RE: Patient call button

Patients should have a call button beside their bed that they can use to call for assistance.

Did the patient know this before they got out of bed?