## FORM E 3A(3)

**SIGNIFICANT EVENT ANALYSIS (CASE STUDY)**

**SAMPLE SEA REPORT**

**Title:** Prescription collection mix-up leading to a patient overdosing
**Date of significant event:** 10 March 2002
**Date of significant event analysis meeting:** 15 March 2002
**Date report compiled:** 18 March 2002

**What happened?**

A patient arrived at the reception desk to pick up a prescription for Amitriptyline. He was given the prescription for Amitriptyline dated the previous day, but in addition there was also a prescription for Amitriptyline which had been lying from the month before and he was also given this prescription. The patient therefore had a large amount of Amitriptyline at home and over the following few days an overdose was taken, with hospital admission and monitoring required.

**Why did it happen?**

The partners, nurse and practice manager discussed the event at a practice meeting and identified the following issues that could have contributed to the event:

The practice does not have a system to identify which prescriptions have not been collected after a given period of time. In addition there is no system to minimise the quantity of potentially dangerous drugs available to patients. Both these issues had contributed to a depressed patient having a large quantity of Amitriptyline. It was also felt that because this man was attending secondary care he had not been formally reviewed in the recent past by any of the partners and so any suicidal intent was not identified by the practice.

**What have you learned?**

There is no foolproof system to stop this patient hoarding medication and subsequently overdosing, however, risk can be reduced.

Change needs to be implemented to put in place a system which regularly checks for "old" prescriptions and allows action, if necessary, to be taken.

**What have you changed?**

The practice decided to implement the following:

A named person to review prescriptions in the prescription box once per month. Prescriptions which have been in the box for 3 weeks or more will be brought to the prescriber's attention and a decision made to keep the prescription and contact the patient or destroy it.

Signed..... Date 12/07/03

Name David Adams