LEARNING CONTRACT

Preceptee Lucy Letby.

Preceptor Y Farmer

Ward NN4.

Date of Contract 22.3.12.

Review Date 22.4.12.

Aim of Learning Contract

1. To identify different drugs given to neonatal patients ~~and~~ their side effects.
2. To be able to prioritise the care of patients allocated.
3. To complete documentation re care of infant.

Plan (how to achieve learning contract aims)

1. Meet up monthly to discuss progress.
2. Identify resources to use to increase knowledge.
3. Develop an understanding of prematurity and problems related to prematurity.

Comments of completion of contract

Date

ongoing development needs.

Preceptee Signature

PD

Preceptor Signature

PD

INQ0008961_0001

Countess of Chester Hospital NHS
NHS Foundation Trust

16th January 2012

Ms Lucy Letby

Dear Ms Letby

Welcome Event

Further to your recent appointment to a position within the Countess of Chester Hospital NHS Foundation Trust, I am writing to confirm your places on the following courses for new staff, which will be held in the Education and Training Centre:

Welcome Event
Date: Monday 20th **February** 2012
Duration: 8.45 – 9.30 Registration and coffee
9.30 to 17.00
When the Welcome Event ends, please report directly to your manager.

Manual Handling / Infection Control Training
Date: Tuesday 24th January 2012
Duration: 8.30 - 16.15

If your course involves a practical session, please wear comfortable clothing (preferably trousers) and low supportive footwear to enable you to take part more safely.

Computer Training
Inpatients Induction
Date: Wednesday 25th January 2012
Duration: 9.15 to 12.15

Patient Care System & Ordering
Date: Thursday 26th January 2012
Duration: 9.15 to 12.30

Basic Life Support Training
Date: Thursday 26th January 2012
Duration: 13.00 to 14.30

A copy of the programme is enclosed for your information. Morning refreshments will be provided on the first day of induction. Lunch can be purchased from the Retro Café or from Vending machines in the Breakout Area.

IF YOU ARE UNABLE TO ATTEND or if you require further information please contact HR Support Services on 01244 366125 or email hr.vacancies@nhs.net

Yours sincerely

HR Support Services

One to One Form

Name:	LUCY LETBY
Job Title:	CHILD BRANCH
Department:	NEONATAL UNIT
Date of 1-1:	30 . 07 . 2013 .

Feedback on actions taken since last 1-1 (this will link to agreed targets and KPI's)
Review with Lucy & reflect critically on the clinical incident which occurred. Drug calculation was correct however the infusion pump Rate was incorrect.

Future actions agreed at 1-1

Action	Deadline	Outcome
~ to continue to care for infants ˢ/c infusions.		
~ is able to check CD's.		
* ~ Go over ˢ/c [illegible] re: Alaris Pump Settings (Calculations).		
6.9.13 - Practice calculations completed with Lucy. I observed doses required being inputted into the Alaris pump by Lucy. We discussed the pump settings and safety features. I am happy that Lucy is competent to use this equipment and calculate various drug doses by intermittent and continuous infusion. PD Neonatal PDN.		

General role review and comments
Review in 6 months. (JAN 30th, 2014).

Employee Signature	PD	**Date**	30 . 07 . 13.
Reviewer Signature		**Date**	30 . 07 . 13.

One to One Form

Name:	Lucy Letby.
Job Title:	Neonatal Practitioner
Department:	NNU.
Date of 1-1:	23-7-13.

Feedback on actions taken since last 1-1 (this will link to agreed targets and KPI's)
Lucy had commenced a continuous infusion of Morphine at the end of her night shift (7am) for a reintubated infant. At 8am on handover infusion noted to be infusing at incorrect rate. Medical staff informed Rate Δ'

Future actions agreed at 1-1

Action	Deadline	Outcome
- Error rectified quickly - no detrimental effect on infant. - Substain from checking any intravenous infusions requiring additives and any controlled drugs until incident reviewed. - Complete intravenous competencies/drug calculation with practice development nurse (Yvonne Farmer).		

General role review and comments
Note to remain in file

Employee Signature	PD	**Date**	24/7/13
Reviewer Signature		**Date**	24/7/13.

Reflection on Drug error:

An error occurred when Gentamicin was given when it was not due and had not been prescribed.

The mistake was realised by myself and a colleague immediately after the dose had been given and my initial concern was for the safety of the baby. The registrar was informed and measures were taken to ensure that the infant was monitored accordingly and that no harm had occurred. I felt disappointed in my clinical practice and role as a nurse, and the impact this had had on a baby and the team around me. I was well supported by colleagues and my manager.

The error has encouraged me to reflect upon my clinical skills and practice, in particular, the way in which I draw up and administer medications. There is a prescription chart and check list already in place for the process of administering Gentamicin, however, myself and my senior colleague failed to adhere to it accordingly on this occasion, resulting in a baby being given a drug prior to it being due. Although this had no adverse effects for the baby, it potentially could have.

Although this was an upsetting event it has made me again realise the importance of carrying out all of the relevant checks outlined by the Unit to ensure patient safety at all times. Although not excusable, at the time, myself and my colleague were administering multiple antibiotics all due at a similar time, as well as caring for our own patients (who were ITU) and supporting junior members of the team, including a newly qualified nurse, when the Unit was not fully staffed with adequate skill mix. On reflection, I feel this situation was unavoidable, and care was given to the best of our ability, however, knowing how the circumstances could have potentially ill affected the process of giving antibiotics; I should have been more aware and made an even greater effort to ensure all the relevant checks were made before giving and time should have been prioritised more accordingly, although this would have been challenging.

I do not feel that anything can be added/changed in order to prevent this happening again, however, I do need to develop my own professional role to ensure that I adhere to protocol at all times and adjust my workload/escalate inadequate staffing/skill mix to ensure that a mistake like this does not occur

Lucy Letby April 2016