FOI Request 5828
There were 7 Immediate Safety Concerns in the financial year 2019/2020.

Report 1:
Occurred: 2019 Q2
Site: Salisbury District Hospital
Detail:
My rostered hours are 9-21.30 = 12.5hrs. 1. Rest breaks not taken - only had a 20 min break for lunch. (out of 2 x 30 min breaks) 2. The intensity of calls resulted the Bleep going off whilst i was assessing patients so I felt I had insufficient time to deal with each patients individual problems before being called away for more pressing problems. 3. Lack of Consultant cover this weekend resulted in patients not being seen by a consultant as incorrectly put on the weekend consultant lists which resulted in the FY1 constantly being asked to see patients who had no consultant led plan. 4. I had to have discussions with relatives about withdrawing treatment but was constantly interrupted - this resulted in a suboptial treatment of this patient and their relatives. 5. All of the above resulted in the nursing staff being rude and unsympathetic to us on answering the bleeps and walking on the wards on how we were not in their view answering them quick enough, despite us explaining to them that we were dealing with even sicker patients.
Steps taken to resolve matters
Discussion with Med Reg on call, Dr on the Sunday about the sheer workload and how it was unsafe, and Guardian for safe working hours on Monday.

Report 2:
Occurred: 2019 Q2
Site: Salisbury District Hospital
Detail:
My rostered hours are 9-21.30 = 12.5hrs. 1. Rest breaks not taken - only had a 20 min break for lunch. (out of 2 x 30 min breaks) - I did even have time to go to the bathroom, and when I managed to get 2 mins to go I was bleeped and then subsequently asked why I was taking so long to answer the bleep! 2. The intensity of calls resulted the Bleep going off whilst i was assessing patients so I felt I had insufficient time to deal with each patients individual problems before being called away for more pressing problems (whilst the bleeps were working) 3. Lack of Consultant cover this weekend resulted in patients not being seen by a consultant as incorrectly put on the weekend consultant lists which resulted in the FY1 constantly being asked to see patients who had no consultant led plan. 4. The bleeps broke at 1pm so we could not be contacted by the wards 5. Nursing staff were told to put jobs on the rolling list - but instead some were put on the weekend bloods list and plans that the week day doctors made were changed 6. The trust appears to have no contingency plan for the junior not being contactable - this resulted in many incidences in nursing staff being rude and unsympathetic to us when walking on the wards on how we were not in their view answering them quick enough and ignoring them despite the fact we were informed all wards had been told the bleeps were down and what to do, this also resulted in patients having to wait for us to walk around the wards as there was no way of prioritising by clinical need.
Steps taken to resolve matters
Discussion with Med Reg on call , Dr on the Sunday morning about the sheer workload and how it was unsafe, and Guardian for safe working hours on Monday.

Report 3:
Occurred 7th April 2019
Site: Salisbury District Hospital
Detail:
Typically busy weekend during an exceptionally hectic time of the year for medicine, exacerbated by the fact that this was the first weekend the locums were withdrawn. I was on the weekend consultant ward round until 2pm, had a 30 minute break for lunch, did not have

time to finish my jobs from the ward round before having to take over the ward cover bleep, and subsequently did not manage to take any further breaks for the day. Despite my having taken the bleep from them, my fellow F1 faced similar pressures in workload and we both feel that this has compromised the quality of care we provided. Whilst going from ward to ward to complete our jobs, we would be accosted for more tasks such as rewriting drug charts and prescribing fluids for patients we knew nothing of. Not only did this cause me to lose track of my tasks, it also meant I'd often end up accepting jobs without having had the time to fully gain information regarding the patients' history, thus when my shift was up I'd end up with poor quality handovers to the night team. The workload was simply not manageable by only two F1s. Some ward nurses were also not trained to add jobs onto the rolling list on HAL, and have instead modified entries on the doctors' weekend list leading to much confusion regarding the ward team's management plans. This was especially the case for nurses on surgical wards who had to look after medical outliers. As an example, one entry for checking inflammatory markers had this added on - "please check hair loss, patient very concerned".
Steps taken to resolve matters
Discussed with Med Reg along with fellow F1 has already escalated this issue.

Report 4:
Occurred: 2019 Q2
Site: Salisbury District Hospital
Detail:
1. Similarly intense day of a medical weekend shift, with no extra help for ward cover 2. Breaks not taken: only 20 minute break taken for lunch (rostered for 2x30 minute breaks for a 12.5 hour shift) 3. Bleep system broke down, poor contingency planning - CCOT had to physically track down F1s to inform us that the system was down and the plan was for us to make our way around each ward asking what jobs need to be done. CCOT helped out by physically going to each ward to inform them that the bleep system was down, however some nurses somehow still did not know and were less than sympathetic whilst demanding to know why it took us so long to answer their bleep, even going so far as to record in the medical notes that we were not answering our bleeps. 4. Poor handovers from ward nurses with the intention of getting their patients seen. I ran to Avon ward before handover meeting to assess an acutely confused patient, only to find out that they were fully oriented albeit distressed that they were suffering from hallucinations, which has been known to the ward team since the middle of the week and was already under investigation. They had full insight into the fact that they were hallucinating and was at no risk of harm to themselves or others. I ended up arriving 20 minutes late to handover completely out of breath.
Steps taken to resolve matters
Discussed with Med Reg. Discussed with Dr regarding need for locums/extra help. Issue appropriately escalated by F1

Report 5:
Occurred: 2019 Q3
Site: Salisbury District Hospital
Detail:
Variance from the work schedule
No registrar or SHO. Only one doctor on the ward. Consultant ward round in AM and available but in clinic in afternoon.
Steps taken to resolve matters
Raised concerns with seniors about staffing level

Report 6:
Occurred: 2019 Q2
Site: Salisbury District Hospital
Detail:

Variance from the work schedule
No registrar or SHO. I was the only doctor on the ward. Consultant ward round in AM and but in clinic in afternoon. Another consultant assisted in the afternoon with decisions above my experience level but on the whole I was managing the ward on my own. Workload greatly exceeded what 1 doctor could achieve and several non-urgent jobs had to delayed.
Steps taken to resolve matters
Informed senior staff.

Report 7:
Occurred: 2019 Q2
Site: Salisbury District Hospital
Detail:
Variance from the work schedule
No registrar or SHO. I was the only doctor on the ward. Consultant ward round in AM and but in clinic in afternoon. Another consultant assisted in the afternoon with decisions above my experience level but on the whole I was managing the ward on my own. Workload greatly exceeded what 1 doctor could achieve and several non-urgent jobs had to delayed.
Steps taken to resolve matters
Informed senior staff.

Compiled by, Guardian of Safe Working Hours, Salisbury NHS Foundation Trust.
7th October 2020