Community Services and Learning Disabilities
Quarter 3 Risk Event Statistics
1st October – 31st December 2003

Fareham and Gosport NHS
Primary Care Trust

High Severity Incidents by Service and Type

Service	Patient Incidents	Staff Incidents	Property Incidents	Incident Details	Action
Community Hospitals	1			*Gosport War Memorial Hospital – 22.10.03* Patient's daughter had asked for more pain relief for her father. Doctor had previously given consent to administer Diamorphine injection as required for breakthrough pain. Staff member mistakenly gave 40mg Diamorphone subcutaneously and only on checking saw this was for 24 hour infusion via syringe. Prior to this the actual PRN dose was written up on a previous page.	Doctor immediately discussed with family members using Naloxone to reverse the effect of the Diamorphone but the family declined. Syringe driver stopped immediately. Members of staff spoken to and statements requested by the Service Manager. Critical incident review conducted, comprehensive action plan in place.