SL - to file.

Fareham and Gosport NHS
Primary Care Groups

SUMMARY

Serious untoward Incident report

Rosemary Salmond General Manager Code A

Date and Time of incident:
10.25 am Wednesday 22nd October 2003 .
Dryad Ward, Gosport War Memorial Hospital

Nature of the incident:
Patient, Mr A, on a palliative care regime with a syringe driver managing his pain through the end stages of cancer.

His daughter requested a stat dose of diamorphine as she felt her father was showing signs of break through pain.

Nurse R gave a 40mg. dose sub-cutaneously, checked by Nurse V.

When she returned to the drug chart she realised that she had misread the chart and in fact administered the 24hour syringe dose. The PRN dose was written on the previous page.

Immediate actions taken:
Doctor D was informed and discussed with the fam[illegible]rse the effect. The family declined.

Where file?

The syringe driver was stopped immediately.

Subsequent Actions taken:
The coroner was informed that the patient died at 3.25pm.

Senior Nurse S met with the family who asked if they could see her at a later stage.

Senior Nurse S and Service Manager met with the nurses involved and requested statements from them.

Service Manager spoke to General Manager, Rosemary Salmond informing her of the incident and faxed Risk Event Form to her.

General Manager informed Director of Nursing and Clinical Governance and it was agreed that a critical incident review should be undertaken. This was arranged for 11.00am Wednesday 29th 2003.

General Manager informed communications team and a draft press statement was prepared.

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His daughter requested a stat dose of diamorphine as she felt her father was showing signs of break through pain.

Nurse R gave a 40mg. dose sub-cutaneously, checked by Nurse V.

When she returned to the drug chart she realised that she had misread the chart and in fact administered the 24hour syringe dose. The PRN dose was written on the previous page.

Immediate actions taken:
Doctor D was informed and discussed with the family use of naloxone to reverse the effect. The family declined.

The syringe driver was stopped immediately.

Subsequent Actions taken:
The coroner was informed that the patient died at 3.25pm.

Senior Nurse S met with the family who asked if they could see her at a later stage.

Senior Nurse S and Service Manager met with the nurses involved and requested statements from them.

Service Manager spoke to General Manager, Rosemary Salmond informing her of the incident and faxed Risk Event Form to her.

General Manager informed Director of Nursing and Clinical Governance and it was agreed that a critical incident review should be undertaken. This was arranged for 11.00am Wednesday 29th 2003.

General Manager informed communications team and a draft press statement was prepared.

Service Manager organised support for the nurses involved and arranged for the nurse who administered the drug to be given 4 days special leave.

The administering Nurse has requested to be down graded whilst she undergoes some extra training. She is not to administer controlled drugs until she has demonstrated a competence in this area.

Mrs C, the patient's daughter and her husband were seen by the prescribing Doctor and the Senior Nurse the next day.

General Manager gave statement to the police on Friday pm. Chief Executive informed of the content of this.

Police requested patient's notes and were given them on Saturday October 25th by Senior nurse on duty at Gosport War Memorial Hospital.

Police interviews arranged for Doctor D and the checking nurse on Tuesday October 28th 2003 and for the administering nurse, on Thursday October 30th 2003.

A critical incident review took place on Wed. 29th of October. A copy of the report and action plan will be forwarded in due course.

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CRITICAL INCIDENT REVIEW
DRUG ERROR DRYAD WARD GOSPORT WAR MEMORIAL HOSPITAL
WEDNESDAY 29TH OCTOBER 2003

ACTION PLAN

	Issue	Action Required	Person Responsible	Deadline	Evidence
1	Three drug charts in use	Clinical Pharmacist to undertake spot checks on all wards to ensure Drug Chart Guidance is implemented.	SC	Jan 04 Ongoing	Reports of findings of spot checks.
2	Failure to alert Senior Nurse/Manager in appropriate way.	All staff to know the correct procedure for reporting critical incidents to Senior Manager in and out of hours.	JP/TS	Dec 03	Flow Chart to be widely displayed.
3	Inadequate ward induction	A review of the ward induction to clarify/formulise its content. All newly appointed qualified staff to complete assessment of drug competencies within one week of appointment. Established staff should have drug competencies assessed annually. Nurses involved in drug error to complete an intensive drug administration competency pack. Newly appointed qualified staff to receive syringe driver training. Nurse R not confident to ask for help – mentoring system to be implemented for all staff.	JP/TS/CM's TS/CM's TS/CM's TS/HR JP/TS JP/TS	Jan 04 Ongoing Ongoing Ongoing Ongoing Ongoing	Company Rep Trainer 12/12/03 Training pack purchased.
4	Syringe driver recording sheet not with prescription chart.	Syringe driver recording sheet to be attached to prescription chart. Documents should be	JP/SC	Dec 03	Spot check by Clinical Pharmacist

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		photocopied before being removed from premises.			
5	Nursing staff unclear how to handle performance following error.	All Clinical Policies to give reference to the Performance Management Policy, which will give guidance on actions outside formal procedures.	CS/Personnel Dept	Jan 04	
6	Other related issues.	Review way the organisation handles issues of this nature in the future. In particular, areas related to staff support and communication with others. A de-briefing session with those involved to be organised.	CIR Action Plan Review Group JP	Dec 03 Jan 04	

DISTRIBUTION OF SUMMARY AND ACTION PLAN ONLY:

Executive Team Fareham & Gosport PCT
Clinical Governance Committee
Risk Management Committee
Sue Damarell-Kewell – EH PCT
Joe York – P PCT
Police – D C Davis