

FAREHAM AND GOSPORT PCT

Serious untoward Incident report

Rosemary Salmond General Manager

Code A**Date and Time of incident:**

10.25 am Wednesday 22nd 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 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.

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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.