

**Fiona Cameron - Director of Nursing Clinical Governance**

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**From:** Fiona Cameron - Director of Nursing & Clinical Governance  
**Sent:** 03 November 2003 09:12  
**To:** Code A; Adrian Osborne  
**Cc:** Ian Piper - Chief Executive F&G; Rosemary Salmond - OT District Advisor  
**Subject:** SUI GWMH - REPORT

Attached is the serious untoward incident report we discussed on Friday with a copy of the proposed press statement. Please let me know if this is the kind of thing you would expect, despite its' being retrospective in this case.

Many thanks.



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Serious untoward  
incident repo...

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**Fiona Cameron**  
**Director of Nursing and Clinical Governance**  
**Fareham and Gosport PCT**

**FAREHAM AND GOSPORT PCT****Serious untoward Incident report**

Rosemary Salmond General Manager 01329 229420

**Date and Time of incident:**

10.25 am Wednesday 22<sup>nd</sup> 2003  
Dryad Ward, Gosport War Memorial Hospital

**Nature of the incident:**

Patient, Mr Alfred Hickman, 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 Robinson gave a 40mg. dose sub-cutaneously, checked by Nurse Vargese.

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 Davies 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 Scammell met with the family who asked if they could see her at a later stage.

Senior Nurse Scammell and Service Manager Janet Peach 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 29<sup>th</sup> 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 Cullen, 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 25<sup>th</sup> by Senior nurse on duty at Gosport War Memorial Hospital.

Police interviews arranged for Doctor Davies and the checking nurse, Leena Vargese on Tuesday October 28<sup>th</sup> 2003 and for the administering nurse, Christine Robinson, on Thursday October 30<sup>th</sup> 2003.

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

Approved by IP/AP/RS

**Fareham and Gosport**  
Primary Care Trust



**PRESS STATEMENT TO [INSERT NAME]**

Fareham and Gosport Primary Care Trust (PCT) regrettably confirms that on Wednesday 22 October 2003, a drug was incorrectly administered to a patient at Gosport War Memorial Hospital. The patient, who was terminally ill with cancer and receiving pain relieving medication, died later the same date.

The drug administration error was quickly recognised by nursing staff who promptly notified senior clinical management at the hospital who took immediate action. The PCT has been kept informed of the incident and has remained in contact with the patient's family.

The PCT has immediately launched a critical incident review and action has been taken to ensure staff members concerned will be supervised, and if necessary undertake retraining, until their competencies have improved.

**[insert date]**

File

Sent to Exec team  
PCPCT / EHPCTFareham and Gosport **NHS**

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PDUCCO

CGC

RMC

**SUMMARY****Serious untoward Incident report**

Rosemary Salmond General Manager 01329 229420

**Date and Time of incident:**10.25 am Wednesday 22<sup>nd</sup> 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 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 29<sup>th</sup> 2003.

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

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Primary Care Groups

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 25<sup>th</sup> by Senior nurse on duty at Gosport War Memorial Hospital.

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

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

**CRITICAL INCIDENT REVIEW**  
**DRUG ERROR DRYAD WARD GOSPORT WAR MEMORIAL**  
**HOSPITAL**  
**WEDNESDAY 29<sup>TH</sup> OCTOBER 2003**

**ACTION PLAN**

	<b>Issue</b>	<b>Action Required</b>	<b>Person Responsible</b>	<b>Deadline</b>	<b>Evidence</b>
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.	JP/TS/CM's	Jan 04	
		All newly appointed qualified staff to complete assessment of drug competencies within one week of appointment.	TS/CM's	Ongoing	
		Established staff should have drug competencies assessed annually.	TS/CM's	Ongoing	
		Nurses involved in drug error to complete an intensive drug administration competency pack.	TS/HR	Ongoing	
		Newly appointed qualified staff to receive syringe driver training.	JP/TS	Ongoing	Company Rep Trainer 12/12/03 Training pack purchased.
		Nurse R not confident to ask for help – mentoring system to be implemented for all staff.	JP/TS	Ongoing	
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

## Fareham and Gosport



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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**



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