NHE000629-0001

PORTSMOUTH

HealthCare

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TRUST

To Bill

From Trevor.

Portsmouth HealthCare NHS Trust

19 JAN 1996

WITH COMPLIMENTS

General Manager, Fareham/Gosport

COMMUNITY HEALTH SERVICES

Gosport War Memorial Hospital
Bury Road, Gosport, Hants PO12 3PW
Tel: 01705 524611 Fax: 01705 580360

UNTOWARD INCIDENT REPORT

Date of Occurrence: The night of the 13th/14th January 1996

Ward/Department: Daedalus Ward.

Locality: Gosport War Memorial Hospital.

Brief Description of Incident: Medication given to wrong patient. Oral Oromorph 80mgms was given to Mrs. Ivy Smith a 90yr old lady in error. at 10.15pm on the 13.1.1996. The mistake was not realised until 02.45am on the 14.1.95 at which time the patient was found to have difficulty breathing.

Immediate Action: Attempts made to rouse patient. The on call Doctor was contacted and patient was transfered to Haslar Hospital on a 999 call. Relatives were informed of events and patients transfer.

Result/Outcome: Patients adverse reaction to the medication caused her condition to be critical.

~~Patient~~ Mrs Smith died on the 17.1.96 in Haslar Hospital.

Inquiry Established?

YES ☑

NO ☐

If Yes undertaken by ...Mrs. Barbara Robinson...

Information to Press

YES ☐

NO ☑

Manager Responsible: Mrs. Isobel Evans.

TO BE RETURNED TO TRUST CENTRAL OFFICE, ST JAMES' HOSPITAL AS SOON AS POSSIBLE

PORTSMOUTH HEALTHCARE NHS TRUST

Managers Report on Drug Error 13th January 1996

On Saturday the 13th January S.N. M. Jarman was the trained nurse on Night Duty for Daedalus Ward. On duty with her was Code A

At that time there were 20 elderly patients on the Ward. These patients are all highly dependant requiring a large nursing input.

Two patients on the Ward required controlled drugs to be administered at 10 pm - Code A and Code A

S.N. Jarman asked Code A to check these drugs with her. First they prepared Code A medication, carefully checking details on the Drug Chart and recording details in the Controlled Drug Register as they progressed. Code A was boarded for 80 mgms of Oromorph Elixer. S.N. Jarman signed the book as the administrating nurse as this was her normal practice, but then asked Code A to give Code A the Oromorph while she put away the Oromorph Elixer used for Code A and took out the mixture for Code A

At this time S.N. Jarman states she was conscious that it was getting late and the patients were already falling to sleep, her normal practice would have been to give the patient the medication herself and then return to prepare for the second patient.

Code A returned from giving the medication and they continued to check Code A medication.

Neither nurses at this time realised a mistake had been made.

Mrs. Ivy Smith had vomited several times that evening and the nurses had spent a considerable time with her due to this. Both Mrs. Ivy Smith and Code A were referred to by the nurses by their Christian name, which may have a reflection on why the error was made.

Until that evening S.N. Jarman had not had any contact with Mrs. Ivy Smith. At 10 pm when she gave Mrs. Smith her Temazepan she found her sleepy.

S.N. Jarman's normal practice is to do a round on completion of the evening duties to make a final check on patients and update Care Plans before putting all the lights out. When she did her round that evening at approximately 11 pm she made a point of checking Mrs. Smith closely as she had been vomiting and she appeared to be sleeping peacefully.

The nurses do regular checks on the patients as not all are capable of summoning help if they require it.

It is their normal practice between 2 am and 3 am to do a thorough round of the patients, checking to ensure beds do not need changing etc.

At approximately 2.45 am Code A and Code A approached Mrs. Smith to check her, on seeing her name on the bed Code A realised she had given Mrs. Ivy Smith the medication intended for Code A On switching on the light they noticed her breathing was abnormal and asked S.N. Jarman to come to see Mrs. Smith - S.N. Jarman was at her break at this time and returned to duty.

S.N. Jarman found Mrs. Smith to be very pale, her respirations were shallow, slow and laboured. Attempts to rouse Mrs. Smith were unsuccessful. The Duty Doctors number was rung and found to be the Deputising Service. The Doctor on call rang and suggested transferring Mrs. Smith on a 999 call as he did not carry any antidote.

Mrs. Smith left the Ward at approximately 3.13 am.

Mrs. Smiths daughter, Code A was contacted and informed of Mrs. Smiths transfer and that she had been given another patients medication in error.

The Staff Nurse in Charge of the Hospital S.N. Webb was informed of events.

S.N. Webb rang me at home at approximately 3.15 am and informed me of events. Considering the time of night I decided there was little point in ringing the Duty Manager until later. I rang at approximately 9 am and reported the incident to Rosemary Salmon the Manager on duty.

On my return to the Hospital at approximately 2 pm on the 15th January 1996 I was informed Code A Code A had called in that morning to see me. I later saw her at approximately 4.30 pm on Daedalus Ward where she had come to see Dr. Lord, Code A daughter was also present with her.

I confirmed events known to me at that time, including the amount and drug used. They had not been told initially that the drug was Oromorph.

I apologised for the incident and ensured them that it would be investigated thoroughly, but until I had seen Mr. Abbotts, I could not confirm if an external investigator would be appointed or otherwise.

They asked if they could be sent the results of the investigation when available.

I agreed to write to them when I had seen Mr. Abbotts and confirm our decision.

I interviewed S.N. Jarman on the evening of the 15th January 1995 who gave me details of the events.

Both she and Code A have been completely devastated by the incident. To use S.N. Jarman's words "It was the worst day of my life"

S.N. Jarman acknowledges the responsibility for this incident is totally hers and is distraught, not only for the suffering of Mrs. Smith and her family, but also for the distress she has caused Code A Code A

Both the nurses in question have proved themselves to be reliable, caring and conscientious staff in the past, not giving me any reason to doubt their ability or judgement. I therefore saw no reason to suspend either staff.

I met with Mr. Abbotts on the morning of the 16th January 1995 at which time we agreed that an external investigator should be appointed, Mrs. Barbara Robinson was requested to undertake this role.

It was also agreed at this meeting that S.N. Jarman should not be allowed to administer medications until the outcome of the investigation.

Mrs. Jarman was informed of this decision and agreed to it without objection.

On phoning Haslar Hospital on the 17th January 1996 we were informed that Mrs. Smith had died earlier that morning.

Code A

I. Evans
Hospital Manager

CONFIDENTIAL

PORTSMOUTH & S.E. HAMPSHIRE HEALTH AUTHORITY

PATIENT ACCIDENT/INCIDENT REPORT

NOT to be used for staff

Please use a ballpoint pen and PRINT ALL NAMES. Complete boxes as appropriate

1. LOCATION DETAILS Hospital/Health Centre GOSPORT WAR MEMORIAL

Ward/Department/Clinic/Other DAEDALUS

2. PATIENT/CLIENT/VISITOR DETAILS (Delete as appropriate) Hospital or GP Record number

Surname SMITH Date of Birth 26 12 04 Age(Years) 91

Forenames IVY Male ☐ Female ☐ Consultant Dr LORD

Address Code A G.P. Dr BARTON

Post Code PO12 1TD

Number of previous accidents over last month ☐ Mental Health Act Status. Section ☐ (See note 2)

3. ACCIDENT/INCIDENT DETAILS Date 13 01 96 Time 22 15

Location details (e.g. bathroom, main ward) MAIN WARD ROOM 9

Reported by Code A TO SINJARMAN Number of other witnesses — (give details overleaf)

Describe what was seen and what was reported ORAMORPH 80mg given to Mrs IVY SMITH instead of to Code A at 22.15. Mistake not realised until 02.45 when patient found to be having difficulty breathing. 999 call at 0315 approx. Relatives

Immediate care given informed. Transferred to Haslar.

Name of doctor informed Deputising service Date 14 01 96 Time 0245

4. MEDICAL/NURSING REPORT (To be completed by examining doctor/nurse. See note 4)

Injuries found or suspected No ☐ Yes ☐ Brief description (site, severity)

Action Treatments/Investigations ordered

Signature of doctor Date Time

Results of X-Rays/Investigations

5. LOCAL ACTION

Was equipment involved? NO ☐ YES ☐ → Description

→ Sent for repair? → Yes ☐ No ☐ → Withdrawn from use? NO ☐ YES ☐ Retained for inspection? YES ☐ NO ☐

Details of occurrence recorded in Nursing Record/Kardex YES ☐ NO ☐

Next of kin/relative/carer informed? YES ☑ Date 14 01 96 NO ☐ Why not

→ Who was informed DAUGHTER How? (e.g. telephone, in writing) TELEPHONE

Manager informed? NO ☐ YES ☑ How? TELEPHONE (MRS EVANS)

Report completed by: Name M A JARMAN

Signature M A Jarman Date 14 01 96

Job Title STAFF NURSE

Date completed form sent to Service Manager 14 01 96

6. MANAGEMENT ACTION Date report received

Name Job title

Further investigation of the occurrence required? NO ☐ YES ☐ (Give details of investigation overleaf if necessary)

Occurrence notified to the Health and Safety Executive YES ☐ NO ☐

Signature Date

Code A

IE/LP

17 January 1996

2228

Dear Code A

Further to our conversation of the 15th January 1996 I write to confirm the arrangements for the investigation into the incident which resulted in your Mother, Mrs. Ivy Smith, being given medication in error.

We have decided the investigation should be undertaken by an external investigator and a Manager with experience in Hospital Management is to be appointed for this role. The investigation will look at this incident and the current practice of administrating medication in this Hospital.

I will write to you again on completion of this investigation.

Meanwhile, if I can be of further assistance to you please do not hesitate to contact me again.

I was very sorry to hear of the death of your Mother this morning and forward our condolences to all the family.

I can only re-enforce our regret over this incident and assure you that we will be co-operating fully with this investigation to ensure our procedures are as safe as possible.

Yours sincerely,

Mrs. I. Evans
Hospital Manager

Copy to Trevor