Hampshire and Isle of Wight
Strategic Health Authority

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SUI Media & Briefing

1. Use this form to provide a briefing to **Department of Health Media Centre** and/or **Directorate of Health and Social Care Briefing Unit**.
2. **INFORMING MEDIA CENTRE**: During Office Hours this should be discussed with Health Authority comms and emailed to Code A @doh.gsi.gov.uk (or if urgent telephone Code A or Code A. Outside Office Hours you may wish to get comms advice (contact Code A on Code A before contacting the DoH the duty press officer on Pager Code A
3. **INFORMING BRIEFING UNIT**: During Office Hours this should be emailed to Code A Code A and Code A Outside Office Hours you should contact the DHSC-S Duty Officer by ringing Code A and asking for pager SER101 if you have an issue that you think needs urgent briefing that cannot wait until the next working day.
4. A copy of this Media & Briefing Note should also be placed in the appropriate SUI file.

SUI Code (use this to help DoH/ DHSC track progress with a specific SUI)	HIOW-2003-	
Date of making this report	21 April 2004.	
NHS Org Code, or Name of Organisation involved	Fareham + Gosport PCT	
Strategic Health Authority Reporting Officer (name and contacts details)	**Name:**	
	Job Title:	Communications Manager
	Telephone:	Direct: 023 8072 xxxx Fax: Code A Mobile: xxxx xxxxxx Out-of-Hours: Code A
	E-mail:	Firstname.lastname@ Code A
Strategic Health Authority Lead Officer (name and contacts details)	**Name:**	
	Job Title:	
	Telephone:	Direct: 023 8072 Reception: Code A Out-of-Hours: Code A
	E-mail:	
Name and contacts details for the NHS organisation involved	**Name:**	Fiona Cameron
	Job Title:	Director of Nursing + Clinical Governance
	Telephone:	Code A
	E-mail:	Code A
Apparent outcome in terms of patient harm (Please circle appropriate response)	None/ Minor/ Moderate/ Major/ Catastrophic (Major circled)	
When did the incident occur?	**Date:** 21 April	**Time (24 hr clock):** 12.30pm.
Where did the incident occur? (Exact location and, where relevant, specialty)	Sultan Ward, GWMH.	
Information about patients/carers etc. involved (Patient description, NOT name(s), including gender and, where possible, age and other demographic characteristics)	Female palliative patient, Aged 86 yrs	

Information about staff involved (Designations, NOT names)	GP, Nurses + Pharmacist
What happened? (Give a factual account of the incident, including a description of: any medical devices or equipment involved; and any medicines involved)	Ward pharmacist in reviewing prescriptions discovered the ~~pt~~ was prescribed paracetemol + co-codamol concurrently + had been receiving these over a period of 5 days.
Other information not in the public domain (Provide a brief overview of any other material factors that are not and should not enter the public domain, or indicate whether other information is available)	Poisons Unit have confirmed over-dose of paracetemol. Parvalax has been prescribed + discussed with family - has been refused.
Describe any immediate action taken to protect and/or improve patient safety.	As above - plus, GP reminded not to prescribe both drugs together. Liver function tests underway.
Has, or will information on this incident be reported to any other agency/body? (Specify).	N/A
Information about actual or likely media interest	Possible - family aware of incident.
Information about "lines to take" (include local and suggested national lines, if appropriate)	LOCAL This is a prescribing error picked up by the new hospital pharmacist at GWMH. The family are aware. Staff ~~will~~ have had notification of the issue pending