Medicines Management

Learning from Medicines Errors

NHS Coventry and Warwickshire Partnership NHS Trust

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Reporting of errors is very important; it is the start of the learning process for our Trust. It is vital that we share the learning and review our practice . All errors in this bulletin were reported between July & September 2024

HIGHLIGHTING—KEEPING MEDICINES SAFE &SECURE

It is essential that medicines are kept safe & secure, this includes being stored in the correct location, at the correct temperature and out of date medication is disposed of immediately following MMG6
Medicine storage and security is also essential for patient safety; if the medicine is not stored in the correct location and securely it may not be available for your patient's next dose

During this period 10% of errors reported were related to the storage of medicines & date expired medicines

Whilst undertaking the check of medication within the clinic, it was noticed that the clonazepam 2mg/5ml oral solution had expired on the 12.08.23. There was no other supply on the unit and doses had been signed as administered on the drug chart. **When administering medicines ensure the expiry date is checked (MMG11).** On opening a new liquid medicines bottle a date opened label must to be used to show the expiry date..	Medication delivery received on the 12/9/23 at outpatient reception desk. However nursing clinicians were not notified by administrative colleagues and therefore medication was not logged and locked in medication cupboard. **Ensure that all medicine deliveries are logged, reconciled with the order/delivery note and stored in the correct location in the correct timeframe (MMG4).** Even when busy, focus on the task Medication should not be left unattended at any time
Respite Centre called to see if we had a child's emergency medication in date in school. I had incorrectly assumed we did, and when the respite staff arrived to collect the in date medication it was also found to be expired. Parent informed and is aware that emergency medication is expired in school and will be needed as soon as possible. **The date of all medication stored must be checked regularly**	When visiting a ward and checking the stock medication in the cupboard and noticed that a strip of levothyroxine 50 microgram tablets had been put in the box of levothyroxine 25 microgram tablets. **When storing medicines always ensure strips of medicine used are returned to the original box.** Storing medication in the wrong container may lead to a patients receiving the correct medication/dose

HIGHLIGHTING—CORRECT DOCUMENTATION FOR THE ADMINSTRATION

It is essential that administration of medicines is completed following a validated authority to administer (e.g. a valid prescription or MAR chart) and documented in a timely manner.
If the authority to administer is not valid or the administration of a medicine is not documented in a timely manner it can lead to missed doses or patients being given additional doses

During this period 26% of errors reported were related to does of medication not being administered (missed) and 17% relating to documentation (administration not record or Kardex/MAR chart authority to administer not correct

34 incidents were attributed to 'Drug not given' 14 of the missed doses were for high risk medications (insulin & anticoagulants) **Medicines should be administered at the times prescribed to avoid potential issues for the patient**	Depot medication had been administered after the outside of the prescription date. The prescription is only valid for 6 months after the last review in this case 10/11/23. The most recent administration of the monthly depot was given on 27/06/23. **Check the validity of the prescription prior to administration**	When signing the medication for Patient A, Staff A noticed that on the previous day that Staff B had signed for 20:00 feed (Nutrison Energy) but that medication not available and therefore is an error on the MAR chart. **Ensure the administration is documented correctly and if an alternative is given tat this is prescribed appropriately**
MAR chart has been transcribed following diabetic nurse review, however the second signature was not on the MAR chart and staff have been visiting for 3 weeks to administer insulin **Check the validity of MAR chart prior to administration**	When carrying out drug card audit the following was noted; Patient B - x2 boxes not initialled **Ensure administration is documented in a timely manner**	A community patient due monthly paliperidone depot had no Kardex in place. The medication could not be ordered or administered, and a dose was missed. **Ensure a valid prescription / administration is chart is in place**

Actions required:

- Complete administration records completed in a timely manner after the dose has been given Check the expiry date of a medicines before administering
- Ensure authority to administer is in place & valid before administering medicine
- Ensure medicines are stored correctly, in the right box, right cupboard, right temperature
- Ensure all medication is administered as prescribed, missed doses could potentially affect a patients health e.g. missed insulin

Could this learning prevent similar errors happening in your area? Please discuss within your teams.

*For further information / comments / queries please contact the **Medicines Management Team** at Wayside House on 024 76536836*

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