Medicines Management

Learning from Medicines Errors

NHS Coventry and Warwickshire Partnership NHS Trust

Issue 28 Spring 2025

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—December 2024

HIGHLIGHTING—Ensuring the ' 6 RIGHTS' are followed for the administration of medicines

It is essential that **all** medication is administered correctly, to ensure patient safety and the required therapeutic response. In the period covered by this bulletin 75% of the medication incidents reported were attributed to 'Administration' incidents with wrong patient, wrong drug wrong dose, wrong formulation and wrong time all being reported.

- When adding incident please ensure the correct process and reason for the error are recorded so we can review our guidance to ensure it is relevant and understood.
- Ensure all incidents including 'near misses are reported following the Trust policy for Incident Reporting.

During this period 75% of incidents reported were related to administration

The 'Rights' of medicine administration were originally described as the '5 Rights' but these have been reviewed and the number of 'rights' increasing. There are documents citing 6, 7, 8, 9 and up to 14 Rights.

NICE detail the '6 Rights' - **An additional point to this list is 'Right Documentation'**

When administering medicines ensure you follow the 6 Rights of Administration and complete the administration with 'Right Documentation' - record the administration on EPMA or paper administration record immediately.
If you do not administer a dose for any reason document this as well

Medicines administration is a process that if not completed correctly could lead to patient harm if any of the 6 Rights are not followed.

HIGHLIGHTING—The importance of recording Medication Incidents including selecting the most appropriate harm level at the time the incident is recorded. Over the last two quarters approximately 20% of incidents do not have a harm level recorded. The majority of medication incidents can be recorded as 'Near Miss' or 'No Harm' and occasionally 'Low Harm' if a patient has received additional observations. If needed the harm level can be updated if an increased level of harm becomes apparent

In this bulletin we focus on the **importance of careful checking when prescribing/dispensing/administering medicines**

Get it right		
Right Person	*Right Time*	Right Drug
•Patient A was given patient B prescribed medication at morning medication round. •During community meeting, patients disclosed how some of the staff both permanent and agency are not administered the correct medication either wrong dose or wrong patient. ***Action:** Always check the patient's identity with the prescription prior to administering medication*	•Cosmocol 3.45g sachet administered at 18:30 instead of 06:30am. I have misread 6:30am for 6:30pm and administered at wrong time. •Staff administered medication (Gabapentin) at 18:00pm instead of 22:00pm •Patient A administered quetiapine 200mg dose at 1730 and also at 1900 ***Action**: Ensure the prescription is checked correctly for the administration time* *Medicines given at the wrong time or not given at all may impact adversely on patient health/care.*	• Pupil had a vaccination consent form, consenting to MENINGITIS ACWY and declining DIPHTHERIA/ TETANUS/ POLIO, nurse did not look at the consent from properly and gave the diphtheria/ tetanus/ polio vaccine in error alongside the meningitis ACWY vaccine. • Patient due 300mg XL Venlafaxine, however RMN accidentally administered 300mg XL Quetiapine • Administered Tamsulosin 400migrograms by error instead of Co-amoxiclav tablets at 14:35. • ***Action:** Check prescriptions/consent forms carefully and only administer in accordance with what is prescribed.*
Whatever our role, we need to work together as a team, especially at transitions, communicating with others and checking carefully. **Keep Alert! Always check carefully and avoid assumptions**		

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*

- *Partnership Trust Acting Chief Pharmacist - **Sarfraz Bolia** (Sarfraz.bolia@covwarkpt.nhs.uk)*
- *Newsletter authors - **Heather Beadle/Tracy Ewing**, Partnership Trust Clinical Governance Pharmacists (clingov.pharmacist@covwarkpt.nhs.uk)*