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 January - June 2025

HIGHLIGHTING—Ensuring the need to complete the correct 'Type of Error' field when reporting an incident. 25% of incidents were reported as 'Other' when incidents were reviewed by Governance pharmacist this reduced to 1% correctly being added as 'Other'

It is essential that **all** medication incidents are reported under an appropriate reason (Type of error), to ensure the incidents can be reviewed appropriately so processes and MMGs can be reviewed to support patient safety and the required therapeutic response.

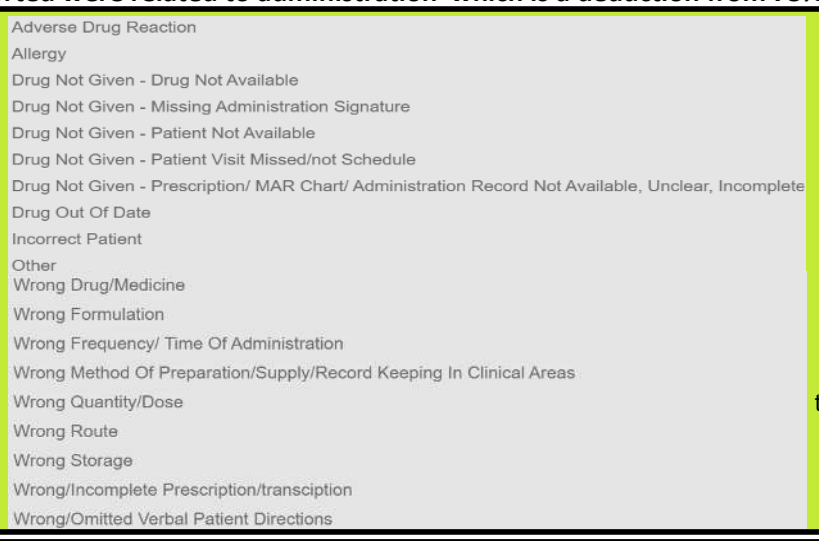
- When adding incident please ensure the correct process and reason for the error are recorded so we can review our guidance to ensure it is relevant and understood.
- Ensure all incidents including 'near misses are reported following the Trust policy for Incident Reporting.

During this period 55% of incidents reported were related to administration which is a deduction from 75%

Updated 'Types of Error' options ➔

The 'Types of errors' options have been reviewed and updated to enable the incident reporter to select an appropriate reason.

- The details under all the 'other' incidents were reviewed to ensure the new options covered all incidents reported
- Reason codes not being used have been removed
- Some reason codes have been amalgamated to reduce the list of options
- Ensure you review all possible reasons when adding an incident (you will need scroll down the list to see all options)



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

Examples from reported incidents

Right Patient	***Right Dose/Quantity***	**Right Drug**
•Patient was administered the incorrect medication, nurses looked at incorrect EPMA screen for another patient. • During 48-hour discharge follow up, observed TTO - Codeine Phosphate 30mg from discharge had label for different patient on ward. •Medicine was collected from the pharmacy and delivered to the address noted; patient later called stating they had not received this - medication was delivered to wrong house number •***Action***: *Always check the identity of the person against the medication label and ensure the audit trail is completed when delivering medicines (MMG05)*	•A drug error occurred when patient was given 600mgs of Zuclopenthixol IM instead of the prescribed dose of 100mgs of Zuclopenthixol. •Patient A was given 60mg of methylphenidate XL in the morning but was prescribed 50mg of methylphenidate XL. •This morning I administered 800 units of colecalciferol instead of 50,000 units as prescribed ***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.*	• Patient A requested PRN medication. Staff A gave 25mg Rapid tranquillisation promethazine oral instead of PRN lorazepam which Patient A accepted. • Patient that was prescribed nitrofurantoin immediate release tablets 4 times a day had been receiving modified release. Medication taken from the Emergency Drug Cupboard • Medication supplied was Metformin 1 gram but labelled as metformin 500mg. Patient dose was supposed to be 500mg. • ***Action:*** *Check the label against the medication in the pack before administering 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*

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