Wellington House
133-155 Waterloo Road
London SE1 8UG

T: 020 3747 0000
E: nhsi.enquiries@nhs.net
W: improvement.nhs.uk

13 February 2017

[redacted]
By email
[redacted]

Dear [redacted]

Request under the Freedom of Information Act 2000 (the "FOI Act")

I refer to your email of **16 January 2017** in which you requested information under the FOI Act from NHS Improvement. Since 1 April 2016, the Patient Safety functions under section 13R of the NHS Act 2006 have been exercised by the NHS Trust Development Authority, as part of the integrated organisation known as NHS Improvement.

Your request

You made the following request:

1. Please take this as a request for copies of all data held about Mirabegron from November 2012 until the 15th January 2017 in particular but not limited to concerns about the safety of Mirabegron which as explained in [redacted] *expert reports caused me life threatening severe hypertension. I require full copies of this information so that I can understand how best to manage the serious hypertension that has been the result of being prescribed Mirabegron.*

Decision

NHS Improvement holds the information that you have requested and is disclosing that information, subject to withholding personal information which identifies specific individuals (e.g. names). The personal information has been removed from the material disclosed having regard to our obligations under the Data Protection Act and on the basis of the exemption for personal data in section 40 of the FOI Act. We explain the information we are disclosing, and the application of the s.40 exemption, in more detail below.

The information we hold on Mirabegron is from the National Reporting and Learning System (NRLS). By way of background, some information about the NRLS may be helpful. The primary purpose of the NRLS is to enable learning from patient safety incidents occurring in the NHS. The NRLS was established in late 2003 as a largely voluntary scheme for reporting patient safety incidents, and therefore it does not provide the definitive number of patient safety incidents occurring in the NHS.

All NHS organisations in England and Wales have been able to report to the system since 2005. In April 2010, it became mandatory for NHS organisations to report all patient safety incidents which result in severe harm or death. All patient safety incident reports submitted to the NRLS categorised as resulting in severe harm or death are individually reviewed by clinicians to make sure that we learn as much as we can from these incidents, and, if appropriate, take action at a national level.

The NRLS is a dynamic reporting system, and the number of incidents reported as occurring at any point in time may increase as more incidents are reported. Experience in other industries has shown that as an organisation's reporting culture matures, staff become more likely to report incidents. Therefore, an increase in incident reporting should not be taken as an indication of worsening of patient safety, but rather as an increasing level of awareness of safety issues amongst healthcare professionals and a more open and transparent culture across the organisation.

A recent search of the NRLS was carried out of all incidents reported as occurring between the dates 1 November 2012 to 15 January 2017 if these had been uploaded to the NRLS by 22 January 2017 and where the freetext contained the terms 'Mirabegrons', 'Betmiga', and 'Myrbetriq' including misspellings. Whilst we have chosen key word searches in good faith as most likely to identify requested incidents we cannot guarantee that there are not additional relevant incidents that an alternative keyword search strategy might have found.

I can inform you that as a result of this search, 116 patient safety incident reports were identified that contained the term 'Mirabegron' or variations as outlined above. Please see Annex 1 which provides incident details as reported by the original reporter. The incident descriptions provided are verbatim but have been redacted to remove personal data further to the exemption in section 40 of the FOI Act, as explained below. Redactions are indicated by square brackets.

Section 40 – personal information

Under section 40 of the FOI Act, information is protected from disclosure if it is personal data protected under the Data Protection Act 1998 ("the DPA"). Section 40(7) of the FOI Act provides that the relevant definition of personal data is that set out at section 1(1) of the DPA:

"personal data" means data which relate to a living individual who can be identified-

(a) from those data, or
(b) from those data, and other information which is in the possession of, or is likely to come into the possession of, the data controller,

and includes any expression of opinion about the individual and any indication of the intentions of the data controller or any other person in respect of the individual.

Under section 2(e) of the DPA, "sensitive personal data" includes personal data consisting of information as to the physical or mental health or condition of the data subject.

Some of the information requested is being withheld from disclosure under section 40(2) of the FOI Act on the grounds that it amounts to personal data and the first and/or second condition under section 40(3)(a) is satisfied, namely, that disclosure would amount to a breach of the first data protection principle (personal data should be processed fairly and lawfully) and/or is likely to cause damage or distress, which would be unwarranted. The information requested contains personal details of staff involved in the incidents who would have a reasonable expectation that their information would be withheld.

In addition, some of the information within the scope of the request relates to the physical condition of patients involved in the incidents which is being withheld on the basis that it constitutes sensitive personal data under section 2 of the DPA and the first and/or second condition under section 40(3)(a) is satisfied, namely, that disclosure would amount to a breach of the first data protection principle (personal data should be processed fairly and lawfully) and/or is likely to cause damage or distress, which would be unwarranted. The patients involved in the incidents would have a reasonable expectation that their information would be withheld.

Section 40 is an absolute exemption and consideration of the public interest in disclosure is not required.

We also have access to the Strategic Executive Information System (StEIS). StEIS is a database used for the notification of appropriate parties that Serious Incidents have occurred and to manage progress of investigations, as set out in the Serious Incident Framework 2015, please note it does not hold the full investigation report for Serious Incidents. The revised Serious Incident Framework published in March 2015 builds on previous guidance that introduced a systematic process for responding to serious incidents in NHS-funded care. It replaces, the National Patient Safety Agency (NPSA) National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (2010) and NHS England's Serious Incident Framework (March 2013). The framework takes account of the changes within the NHS landscape and acknowledges the increasing importance of taking a whole-system approach, where cooperation, partnership working, thorough investigation and analytical thinking is applied to ensure organisations identify and learn what went wrong, how it went wrong and what can be done to minimise the risk of the incident happening again.

A search of StEIS was also carried out of all incidents reported as occurring between 1 November 2012 and 15 January 2017 if these had been reported to StEIS by 22 January 2017 and where the free text contained the term 'Mirabegron'. As a result of this key word search no incidents were found.

Review rights

If you consider that your request for information has not been properly handled or if you are otherwise dissatisfied with the outcome of your request, you can try to resolve this informally with the person who dealt with your request. If you remain dissatisfied, you may seek an internal review within NHS Improvement of the issue or the decision. A senior member of NHS Improvement's staff, who has not previously been involved with your request, will undertake that review.

If you are dissatisfied with the outcome of any internal review, you may complain to the Information Commissioner for a decision on whether your request for information has been dealt with in accordance with the FOI Act.

A request for an internal review should be submitted in writing to FOI Request Reviews, NHS Improvement, Wellington House, 133-155 Waterloo Road, London SE1 8UG or by email to nhsi.foi@nhs.net.

Publication

Please note that this letter will shortly be published on our website. This is because information disclosed in accordance with the FOI Act is disclosed to the public at large. We will, of course, remove your personal information (e.g. your name and contact details) from the version of the letter published on our website to protect your personal information from general disclosure.

Yours sincerely,

NHS Improvement

Annex 1

This is a summary of 116 patient safety incidents reported by the original reporter, where the incident was reported to the NRLS between 1 November 2012 and 15 January 2017. The incident descriptions provided are verbatim but have been redacted to meet our obligations under the Data Protection Act. Please note any spelling errors or abbreviations are those used by the original reporter.

Incident Number	Incident Description
1	Correct medicine was dispensed under the wrong patient name , therefore patient received the correct the medication but the label had the worng patients name on it . .
2	Patient expecting GP to prescribe Betmiga (mirabegron) . Non - formulary drug . .
3	Pharmacy received a handwritten hospital prescription for patient [Initials] , The script was handed in by patient [Initials] . The item was to be ordered . [Initials] [relative] collected her medicines on the [Date] and also wanted to collect her [relations] medicines . The hopistal script stating patient name [Initials] was handed to [relative] . [Initials] later returned medicine to pharmacy as it was not what [patient] was expecting . Upon investigation with hospital consultant secretary , confirmed that script should was written for [Initials] but incorrectly had [Initials] details . Patient [Initials] did not take any of the medicines . .
4	Clinic letter dated [date] asking GP to prescribe Mirabegron , Patient has not had any previous Anticholonergics Oxybutynin / Tropsium / Totterodine or Solifenacin as tablets or patches . Formulary guidelines not adhered to , 5 options listed before Mirabegron is indicated . According to NICE technology appraisal 290 , Mirabegron is for Gynaecology or Urology Consultant initiation only , no dosing instructions or supporting information included with letter . .
5	Mirabegron 25mg dispensed in place of Mirabegron 50mg .
6	Please review the need to : Solifenacin and mirabegron . Both used for urinary frequency and urgency and urge incontinence . Please review only solifenacin dispensed . .
7	[Patient] was prescribed Mirabegron MR 50mg OM . Morning and Midday circled by Prescriber , patient was therefore given double the dose for 6 days . .
8	Medication request for Mirabegron mr tabs for patient was issued from pharmacy on [date] but the medication was charted as missed dose drug not available . Pharmacy had sent an original container to the ward but this has now gone missing and medication is quite expensive .
9	Patient seen by doctor . Recommended mirabegron 50mg and festerodine 8mg . Later been rejected by [company] (prompted by [company] on GP clinical system) .
10	prescribed mirabegran 50mg daily MAU . Order for drug placed and dispensed on [Date] . [date] a request was made to pharmacy by ward [number] for this drug , prescription showed 6 missed doses (4) .
11	Patient prescribed solifenacin / mirabegron / placebo for the BESIDE clinical trial . Prescription clearly documents a dose of THREE tablets each morning . The approved sample label in the trial specific pharmacy procedure has a dose of ONE tablet each morning . The IMP was labelled as ONE tablet each morning . .
12	Patient transferred from [hospital] this morning with ?cauda equina . A&E admission notes state arrival at [time] . Arrived on [ward] at [time] . No medications are prescribed despite the patient being on a number of important medications , , including : Fentanyl

	patch 50mcg / hr Lansoprazole 30mg Amitriptyline 10mg Pregabalin 300mg Alverine Citrate 120mg Prednisolone weaning dose Mirabegron 50mg MR Atenolol 25mg Baclofen 10mg Adcal D3 Leflunomide 10mg Betahistine 8mg Paracetamol 1g Patient in +++ amounts of pain , , unable to give [gender] anything due to nothing being prescribed . .
13	Mirabegron 25mg daily ordered which is half a 50mg tablet but labelled incorrectly as two 50mg tablets (100mg) daily . .
14	The patient was prescribed Mirabegron m / r 50mg mane on MAR . Mirabegron m / r 25mg tablets issued but labelled Mirabegron m / r 50mg tablets . Dosage two in the morning .
15	Patient admitted to the [Unit] and regular medication charted on the [date] . Pharmacist checked chart on [chart] ; one item was identified as not being in the treatment room so staff sent fax to pharmacy to order as temporary stock . No stock arrived so staff re - sent fax numerous times over the following week . Patient has missed 7 days treatment . .
16	Nurses reported no medication on the ward . Ward pharmacist had seen the medication on [date] but patient had missed doses of both mirabegron and ganfort on [date].
17	The patient was on mirabegron 25mg modified - release tablets , to be taken once daily , and when ordered on the ward sheet , this was clearly stated . Mirabegron 50mg modified - released tablets were dispensed and ward nurses were splitting the 50mg tablets in half to give doses to the patient at 25mg daily . However , this should not be done as they are modified - release tablets . One of the ward nurses flagged this up with the ward pharmacist . .
18	Transfer of information incident : . Patient admitted to [ward] from [ward]. . Mirabegron missing from medisec , (also no note to say stopped , changed etc .) - inpatient notes not reached [company] yet , so unable to reconcile with inpatient chart . Unsure if to continue . . Laxido dose increased from i BD to ii BD - not recorded on medisec . . Patient discharged from [initials] . .
19	Prescription presented for Mirabegron 25mg tablets . Mirabegron 50mg tablets dispensed in error .
20	Pharmacist reviewing chart came across prescription for mirabegron 25mg od prescribed on [date] and marked on the chart as 7 (drug not available) for the last 4 days . No entry has been made on the front of the chart to indicate what action the staff took to obtain the medicine . Nursing staff have not ordered this medicine from Pharmacy and so the patient has not yet started treatment . .
21	For two days running this patient has not received certain medication due to the nurses not looking in the locker or treatment room for the order . Yesterday an order was written out for this patient , but we had already dispensed them the day before so our [job title] informed the nurse looking after this patient that they were still in the treatment room . This morning the same thing happened , an order was given to me , I checked to see if we had already dispensed it , checked the patients locker and they were in there . .
22	This morning during medication round SN [initial] administered mirabegron 40mg to the wrong patient rather than 135mg mebeverine which was prescribed . Both medications are for physical ailments - the mirabegron is for urinary incontinence and urges and the mebeverine is for stomach issues . This was a human error . [job title] informed who then informed [initials] and a plan was put in place . [job title] contacted who advised taking physical observations 2 hourly for the next 6 hrs and to contact if any problems . Pharmacy contacted who gave the same advice . Patient [initials] contacted to inform him of the plan . Patient spoken to by [job title] and [job title] who informed him of the error and any potential side effects . Also apologised to the patient unreservedly . Informed the patient that SN [initial] wished to apologise also to [patient] . The patient was very calm and accepted the news without issue . [Patient] stated that [they] felt ok

	and that " mistakes happen " . [Patient] told [job title] that SN [initial] should not worry about it . Obs taken and so far are within normal limits . Dr [initial] informed and [Dr] stated that [they] will attend the ward this afternoon to take further observations . .
23	Transfer of information incident : . Patient admitted to [ward] from [ward] . Upon completing MR using medisec and GP fax ,) noticed that trospium MR 60mg OD missing from medise ,) but on GP fax . . No documentation to clarify whether or not this was stopped : although could understand why this was stopped , as patient cincurrently prescribed mirabegron , not appropriate to have to interpret from medisec , as this may not definitely be the reason why not included . . New items also not documented as such on medisec . .
24	Mirabegron has been prescribed first line and Wirral formulary has not been followed . Mirabegron should only be used 5th line , , when antimunscarinic drugs are contraindicated or clinically ineffective . .
25	Mirabegron has been prescribed first line and Wirral formulary has not been followed . Mirabegron should only be used 5th line , when antimunscarinic drugs are contraindicated or clinically ineffective . .
26	Type 1 DM . Not given morning insulin until [time] due to not being available from pharmacy . BMs >27.8 . .
27	[date] Patient admitted via [unit] . Poor knowledge of medications , [relative] is main carer . Prescription chart completed using GP repeat slip : - fesoterodine 4mg OD and mirabegron MR 50mg OD prescribed ; - Theophylline (Nuelin SA) 250mg BD prescribed . [date] Medications brought in from home in pillmate and some original packs . Meds Rec carried out using original packs and SCR : - fesoterodine 4mg OD on repeat list , however last issued [date] (switched to mirabegron) [no information added to Meds Rec form] - Nuelin SA 250 last issued [date] [information added to Meds Rec from] - recent acute list shows Uniphyllin Continus 200mg BD ([date]) but neither of these added to meds rec form by pharmacy . [date] Fesoterodine supply required - review of prescription - why on both fesoterodine & mirabegron - checked SCR & with [relative] - fesoterodine stopped in [month] , replaced with mirebegron . Also confirmed which theophylline preparation was currently in use - Uniphyllin Continus 200mg BD . . At no point did the patient receive incorrect treatment as there was no stock available of either incorrect medication . .
28	Patient prescribe newly prescribed Mirabegron on advice of the [job title]. The dose prescribed on the chart was 40mg twice daily . This recommended dose for adults is 50mg once daily by means of a modified release tablet . .
29	patienm had two drug prescription card . one at the end of [patient's] bed , the other in [patient's] medical records . At [time] , I checked with the patient as it was not documented whether [patient] had passed urine . I checked and noted that there was a drug chart missing . on finding it , there was furosemide 80mg bd not given , Chlorphenamine 4mg qds not given at [time] and [time] on [date] and [time] and [time] 0n [date] , Mirabegron 50 mg not given , Mirtazpein 45mg not given on [date] at [time] . .
30	Mirabegron 50mg modified release tablets were dispensed to the patient in [name] Unit on [date]5 . However , this medicine was not transferred to Ward [name] with the patient on the same day , resulting in two missed doses . .
31	Medicines reconciliation and clinical review Mirabegron 15mg po od prescribed , patient takes mirabegron MR 30mg po od at home Also takes ferrous fumarate 210mg po tds at home , but not prescribed .
32	Appropriate department reported they dispensed patient mirabegron and sent to ward , it was not received in ward . .
33	regular meds include lansoprazole 15mg od , mirabegron MR 50mg od , clenil modlite 100 TT OM inh .
34	Patient said to ward doctors that [patient] didnt have one of [their] night medication (

	Mirabegron) .
35	Informed by health care , extra medications found in patients compliance not indicated by Mar chart . Found extra doses of Mirabegron 50mg in patient night time slots . This drug is prescribed as a OD morning dose as documented on Mar chart and on compliance aid label . Noted extra dose had been given [date] [date] . Error noted on [date] by health care , extra dose omitted [date] and [date] . .
36	Prescription from [unit] sent to pharmacy for screening for MIrabegron and Detrunorm . No apparent indication for starting these agents in a [age and gender] following shoulder arthroscopy . . Combination identical to another patient on the unit so likelihood that incorrectly prescribed for this patient . .
37	mirabegron mr picked for dutasteride .
38	Wrong strength selected .
39	Prescription for Mirabegron 25mg m / r tablets , picked and handed out 50mg tablets .
40	wrong strength of mirabegron mr tablets (25mg) dispensed insteadf of correct one (50mg) .
41	Patient given inpatient medications (no directions on labels) for TTA to take home . The medications included : Apixaban , Mirabegron M / R , isosorbide mononitrate , gabapentin and lantus solostar pen . .
42	Patient [initials] transferred from [ward] on [date] . Found Mirabegron for the above named patient who is still on [ward] in the medications transferred with this patient . .
43	[Job title] had completed Medicines reconciliation and thought that Mirabegron was the brand name for MR tramadol (other brand names for tramadol are mabron) . They documeted in the meds rec that the patient was on tramadol , instead of mirabegron . On the drug chart next to Mirabegron , the [job title] wrote ' tramadol' . The nurse giving medication read Tramadol and gave tramadol , This had been given for 5 doses . .
44	patient admitted from [unit] to ward [number] on [date] at [time] . [Patient] was prescibed [their] medication in [unit]. when the pharmacist was doing the medicine check [pharmacist] found that this patient was not on two of the precribed medications . Alendronic acid and mirabegron 50mgs . On closer inspection the medication has a different name on who was from the same nursing home as the patient came from . The patient recieved 2 doses of mirabegron whilst on ward [number]. [Patient] did not recieve alendronic acid .
45	the pharmacy received a RX for mirabegron 25mg and the pharmacist checked 50mg instead .
46	regular medsat home are : depakote 1G BD , Mirabegron MR 50mg om please rveiew .
47	Regular meds - depakote - metformin - procyclidine - mirabegron 50mg OM , please reduce to 25mg od due to decreased renal function - lactulose nicotine patch Steroid - notes state ? background COPD , should prednisolone dose be 30mg rather than 40mg (r / v by dr , [job title] had specifically recommended 30mg , therefore not changed) .
48	Patient regular meds include alendronic acid , atenolol , tramadol , mirabegron and ganfort . .
49	Co - dydramol - consider changing to co - codamol 30 / 500 effervescent Ferrous sulphate - use ferrous fumerate 140mg / 5ml - 10ml bd Mirabegron - no data for NG . Consider alternative Targinact CD - use ocycodone 5mg / 5ml (total oxycodone dose divided by 6 every 4 hours) No data for maloxone refer to pain team .
50	Patients medication admission on admission was documented from GP print out - medication last issued [date] . Patient had since had a number of hospital admissions with significant changes to [patient's] medication (many were evident on [patient's] most recent EDS from CAU) . medication prescribed and administered in error included duloxetine , amiodarone , mirabegron and losartan . .

51	[Bed details] On checking the prescription chart it was noticed that the patients drug history had been clerked in incorrectly in A+E and hence the prescription chart contained two items that were not prescribed for the patient (see below) I was shown a green bag by staff nurse on [unit] which contained x 2 blister packs 1 was labelled with this patients name and the second was for a completely different patient . It appears that the drug history was clerked from both these packs and it was not noticed that the second blister pack was for a [gender] patient and not the actual [gender] patient . (how the two packs were put together in the patients green bag i am unable to explain) the doctor writting the chart copied the drug history from the inaccurate clerking without checking the recent discharge letter (also in the notes and also containing additional medicines such as rotigotine patch , that had not been prescribed on current [unit] chart.)or the PODS Unfortunately , the nurse had given a dose of aspirin as per prescription , which was one of the drugs not on this patients drug history (aspirin and mirabegron) .
52	Dose of mirabegron MR reduced from 50mg to 25mg . This was then ordered by ward staff on the [date] . [job title] the rang [initials] pharmacy on [unit] to enquire about if it was ordered and when it was due to arrive . [job title] was told that it would sent that day ([date]) . [job title] returned to ward [date] and medication wasn't on the ward . Another phone call was made to [initials] pharmacy . [job title] was told that the 50mg tablets had been sent and if the 25mg were required that a new product request form would be needed . This information was then passed onto [job title] . At this stage patient had not received medication for 6 days . [job title] contacted procurement and was informed that " 50mg were sent down on [date] on the assumption that they were scored and could be halved (or would be on the ward with a tablet cutter) . " These tablets are Modified release and are not noted as being scored in BNF . .
53	Patients locker was checked on ward [number] [date] . Quantities of patient own drugs were documneted on the treatment sheet . On [date] when checking chart I noticed that Mirabegron sr was omitted and ns (no stock) written on the chart . On the previous day I had documented that the patient had got 29 in the locker and locker was rechecked and the stock found in locker . .
54	Patient was prescribed Betmiga 25mg by electronic prescription . Box of 50mg tablets were labelled as 25mg and given out to patient . Patient realised the error and returned the incorrect strength the following day .
55	Whilst accuracy checking a prescription I noticed 50mg mirabegron labelled take half a tablet daily was in the OSD bag . The patient was prescribed 25mg daily so dose correct but as mirabegron is a modified release preparation the tablet should not be halved . When the patient was first admitted on [date] I had seen the medicine chart as it had been brought down to pharmacy when I was working on late night . I endorsed it to say pharmacy do not keep , please ask patient to get from home . When I was told that the patient could not get from home I had ensured that the 25mg tablets was added to ascribe and the medication was ordered in . The original order sheet can't be found so I am unsure which member of staff authorised the use of the 50mg tablets . The patient had been having the 50mg tablets 14 days . .
56	Regular meds not prescribed ; - mirabegron mr 50mg po od .
57	Patient was tranfered from [unit] to Ward [number] , without Mirabegron MR medication . The drug chart states that it had already been ordered . Rang Ward ([unit]) , and was told that it was not ordered as a result it is not in their ward . The patient has not been able to have medication it has been marked not available . [date] - pharmacist rang our ward to tell us that they had none of the medication available and that they had sent the last of it to the [unit] on [date] . [job title] [initials] contacted [unit] spoke with ward clerk who found the medication and we sent a member of staff to collect it . .
58	lost medications supplied by pharmacy . including high cost medication ie mirabegron . also lost sertraline , symbicort , bumetanide , losartan , .
59	Patient admitted [date] . Drug history completed by pharmacy [date] and multiple discrepancies identified . Tramadol overdosed , gabapentin underdosed , wrong PPI

	prescribed , not prescribed : cyanocobalamin , mirabegron , hypromellose , clotrimazole . Teams informed daily with entries made in notes . Issues still not addressed [date].
60	The [name] ward order book requested mirabegron for a patient , 21 tablets of which had been dispensed five days previously to [name] ward . [name] staff said that [name] could not find them . .
61	Incorrect drug history documented for pt mirabegron 15mg mr om ststed on dhx pt is on 25mg om - dr managed to rx 15mg on JAC and TTO but patient never recieved any incorrect doses and they wouldnt have been able to administer 15mg either - pt had own 25mg tabs .
62	Prescription received in pharmacy for mirabegron 25mg MR tablets . The label was prepared in accordance with the prescription but 50mg MR tablets were dispensed in error . The error was identified when the patient was in hospital , by which time he had taken 25 of the higher strength tablets . No harm reported by the hospital pharmacist . .
63	([reference number]) Patient prescribed 25mg modified - release Mirabegron and received 50mg modified - release Mirabegron .
64	Prescription request received from [job title] for Betmiga 50mg once a day . Prescription printed by practice as Betmiga take one once a day and prescription was sent to [name] pharmacy in [location] . Pharmacy issued Betmiga 50mg with the instruction Take one twice a day . .
65	Client was on mirabegron 50mg on the older chart and this medication was not carried over onto the new medicine chart . This mistake was discovered when client was going on leave . .
66	Medication accidentally omitted from medication chart when rewriting . .
67	Patients drug history medication - ketoprofen & mirabegron - were stopped on [date] (day after admission) . The latter because patient was catheterised . Neither were administered during the inpatient stay however these were restarted on the TTO - the reason for this is unclear and was not documented in the notes . In addition the patient had oxycodone mr 15mg BD on their TTO despite this being switched to MST 30mg BD on [date] . There was no documnentation in the notes to support that these decisions were intentional . The TTO was checked by a pharmacist . These potential errors were identified by the pharmacist at [name] ward .
68	Clinically checking prescriptions . Saw a prescription for tamsulosin / dutasteride combination capsule which was done yesterday and was marked as having been administered . I did not think we would have this in stock . On checking with the nurse she had given just tamsulosin which was incorrect . On further checking the records there was a duplicate prescription for mirabegron 25 mg tablets , both had been given for the last four days . .
69	The patient arrived in the discharge lounge with [their] complete TTO to await transport . Amongst [patient's] TTO were inpatient supplies of Mirabegron , Paroxetine & co - careldopa . .
70	A patient was prescribed mirabegron on [date] , for [patient's] overactive bladder , at the recommendation of the urologist . [Patient] had ambulatory blood pressure monitoring on [date] . and this did not reveal any raised blood pressure . However , [patient] had [their] blood pressure measured by the [unit] team on [date] . and [patient's] BP was reported to be 202 / 101 . In subsequent monitoring at the practice [patient's] BP remained high . [Patient] was initially treated with hypertensives which controlled [patient's] blood pressure . However , [patient's] mirabegron was stopped by the GP on [date] . following the practice pharmacist reviewing [patient's] medication . .
71	On drug round it was noted that a drug on the previous morning drug round had not been signed for . Mirabegron mr not signed for at [time] .

72	New patient to ward [number] transfer from ward [number] . Ward had ordered some meds which had been supplied to ward [number] on [date] (Mirabegron MR 25 mg OD and Co - beneldopa 12.5 / 50 1 BD) . Meds had not been transferred with patient between wards and were found by pharmacist in ward [number] green returns bin . Patient missed morning dose on [date] . .
73	Patient had a medication history completed by the ward pharmacist using the summary care records on [date] . A member of the medical team went to prescribe the patient regular medication that day and used a discharge summary from approximately 6 months ago . This included several medication which the patient was not currently taking . One such medication , mirabegron , had been supplied by the on call pharmacist overnight and the patient had received a dose . .
74	Patient has had a drug list done by pharmacist on Medical [number] ([unit]) . However , the medications on the drug list do not belong to the patient and are not documented at all on the drug chart . The allergy status also does not match . This drug list has been dispensed by pharmacy . . Medications not intended for patient : - lansoprazole , ramipril , oxytetracycline , bisacodyl , tolterodine , fluoxetine , mirabegron , simvastatin , sinemet , codeine and alendronate . . Drugs intended for patient but not on drug list : - citalopram , doxazosin , multivitamin , senna , laxido , buprenorphine patch .
75	Upon locker checking this [patient] for discharge medication I found a box of mirabegron 50mg mr tablets labelled 25mg mr tablets . dispensed by [job title] . patients dose was 25mg mr , but had been receiving the 50mg mr tablets for 3 days , [date] .
76	Was processing medication queries and wanted to ensure patient had been given full information / warnings about new medication in line with BNF recommendations - need to have adequate contraceptive cover - mirabegron - initiation of drug was recommended by Urologist ([hospital]) NB Patient is [age] female . Rang patient - patient was not aware of need to have adequate contraception cover although she did say she had no plans to have further children . She said nothing about this had been mentioned at her hospital appointment . .
77	patient regularly takes mirbagron - r / v and prescribe as appropriate .
78	Doctor ordered Mirabegron MR 25mg for patient as a night time dose on [date] this was dispensed by pharmacy on [date] . Ward have then marked this item as ' not given , out of stock ' for 4 consecutive days despite repeated conversation with pharmacy informing the ward that this had been dispensed . . On [date] ward phoned dispensary again asking for this item to be dispensed . Pharmacy Technician contacted ward to tell them that it was in the patients green pharmacy bag in their right hand TTO cupboard and that it had been physically seen by pharmacy that same day . . On [date] Technician visited ward and found that medication was still in patients green bag and that again the drug had been signed for as ' not given , out of stock ' . .
79	admission meds - mirabegron 25mg od - omeprazole 20mg od - amitriptyline 10mg on (acute) .
80	Pharmacist selected wrong strength of medication and did not get member of staff to double check so wrong strength given .
81	Patient incorrectly prescribed mirabegron , cephalexin and adcal d3 . The patient was not admitted taking these medicines - it is thought that the medicines were supposed to be prescribed for a patient called [Patient name] who had previously been in that bed . The medicines were incorrectly prescribed for patient and as a supply had been organised for the other patient patient received 1 dose of mirabegron , 2doses of cephalexin and 1dose of adcal . .
82	The patient arrived in the discharge lounge from ward [number] to await [their] own transport home . I addition to [patient's] TTO the ward had given [patient] inpatient supplies of bisoprolol , asasantin , mirabegron & vitA - pos . .
83	Patient had brought [their] prescription list with [patient] but mirabegron not prescribed

	for the 10 days that [patient] has been in .
84	Solifenacin and Mirabegron wad added onto the incorrect patient record , at [hospital] . Patient has taken both medications since [date] , until error found in [date] .
85	Meds rec done : Seretide , ranitadine , oxybutnin , trimtehoprim , mirabegron and amitripityline not prescribed . .
86	Patient is also on Aqueous cream PRN Ferrous gluconate 300mg BD 2 / [date] Mirabegron 50mg MR OD .
87	near miss - nearly administered a duplicate dose of pivmecillinam because patient medications had not been locked away and [patient] had already self administered it , patient had already self administered mirabegran which was not prescribed .
88	Patient was transferred from medicine over weekend . Being discharged today . TTAs checked at [time] to find no mirabegron 25mg with TTAs . Listed on TTA as pharmacy [number] stop on ward (being used for inpatient use as non stock medication) . 1 tablet left in box and was labelled as do not send home with patient . Spoke with ward pharmacist , who said send to pharmacy to be dispenced as TTA and advised to complete aims form as medication dispensing error . .
89	Please review Trospium and Mirabegron - both for incontinence - please review whether both are to be used together intentionally or one or the other . .
90	Medication error caused by incorrect transposing of label to MAR chart . Patient was given mirabegron 25mg twice daily for 5 days instead of the prescribed dose of 25mg od . Label sticker on the MAR was for another patient on the ward also on mirabegron . .
91	Solifenacin and Mirabegron added onto the incorrect patient record . Patient has taken both medications since [date] , until error found in [date] .
92	due to [name] GP surgery making a prescibing mirabegron incorrectly in the nomad prescription . [name] Chemist were late issuing prescription so the nomads did not arrive on ward till patient had been discharged home . nomads then had to be sent to patients house by taxi . No medication was missed during this incident . .
93	Patient self discharged with medication labeled ' hospital use only do not give out on discharge ' . Drugs involved Mirabegron , Fluoxetine , bisoprolol , amlodipine , amitriptyline , carbocisteine . .
94	doing an eDn that had not been validated evening before as requested by DLO so urgent . family were upset as PAL . Pitotifen was documented as BD but SCR when I checked as no perfoma documented was only daily checked with patient and family too and NOMAD tray . No allergies documented yet some on SCR . Both solifenacin and mirabegron were prescribed together (solifenacin started as inpatient as catheter issues ? asked dr to review before validated and solifenacin stopped as wanted to contine mirabegron as pre med . No reducing course for dexamethasone documented on chart . Clarified alternate days for 10 days then stopped . many meds had not been reviewed e.g . quinine ? simvastatin as PAL but did what I could quickly to avoid further delays . .
95	Please reviewing dose and frequencies - re : renal function : - Reduce enoxaparin to 20mg OD - Tazocin 4.5g TDS (eGFR 20-40) - Mirabegron MR : reduce to 25mg once daily . SCR states : Humalog mix 50 - 40 units mane , 20 units in the evening , (no afternoon dose mentioned) . Bisoprolol drug history 2.5mg once daily .
96	medication ordered on [day] and one tablet supplied . Ordered again on [day] , meds didn't arrive on the ward . Discussed with on [name] pharmacy . . .
97	On the morning drug round I popped out two tablets into a pot on the locker on the neighbouring patients bedside space . I walked to the bay drugs cupboard to find another tablet and when I came back to the locker the tablets and pot were not there . The patient who they were for was out in the bathroom . I searched all possible areas for the tablets but could not locate them anywhere . I asked the named pt if [they] had

	taken some tablets from the locker ; [patient] said [they] had only had [their] tablets that day and named them , however the pt is known to have confusion and short term memory issues . I can not be 100% sure if [patient] took the tablets or not but I spoke with the pharmacist and dr on the ward , neither were concerned as if [patient] had taken them , [patient] had only taken an asprin and a Mirabegron MR which shouldn't have any adverse effects . Nurse in charge also informed . . .
98	Reported by the patient that [they] had raised concern to the nurse (SN [initial]) giving [patient's] medication on the morning drug round on [date] that [nurse] was giving the wrong dose of [patient's] MIRABEGRON . (giving a whole tablet instead of half .) [Patient] said the nurse (SN [initial])denied that this was wrong so [patient] accepted it but was very anxious . The nurse (SN [initial]) giving the same medication the next morning gave half a tablet and [patient] checked with this nurse who explained the dosage and why half a tablet was used and [patient] was reassured . Patient said [they] felt SN [initial] made [them] feel very anxious and [patient] does not have confidence that [nurse] understands the medication [nurse] is administering and would not wish to be looked after by [nurse] . .
99	Patient has prescribed 500mg once daily of Mirabegron MR (Betmiga) . The patient was admitted on 50mg , and had brought in [their] own medicines to hospital in a NOMAD tray , where it stated 50mg once daily . The doctor has prescribed a 10x overdose . . The patient did not receive this dose as the medication was in [their] NOMAD box and is not stocked on the ward , so the chart was signed with a ' 5 - Medication not available ' . .
100	Mirabegron M / R doses not signed for 3 successive days , presumably not given . Patient not complaining of spasms around catheter .
101	On [date] the patient was prescribed the following medications in duplicate : Amlodipine tablet PO 5mg OD Enoxaparin injection SC 40mg OD Mirabegron MR tablet PO 50mg OD Predinsolone tablet PO 5mg OD Lamotrigine tablet PO 100mg OD Nursing staff had acknowledged duplicates and patient did not receive additional doses Picked up by [department] pharmacist via [department] report .
102	Please review the following : - Tamsulosin MR 400mcg - unsuitable for PEG feed as per pharmacists note on [date] - review patients mirabegran as per drug history once patient Twoc'd - GTN spray missing from TTO .
103	Chart was sent up to pharmacy on [date] morning to order Mirabegron tablets for a patient . No order book sent with chart . Ward on chart said [name] . I was the on call pharmacist that day and was bleeped around [time] from [unit] , saying that the chart for this same patient had been sent to [ward] . Had got the chart back but they couldn't find the tablets . .
104	when doing medication round it was observed that new patient [initials] admitted on [date] Mirabegron was not signed on the prescription chart and had been given , also the rest of the prescribed medication had not been dated or checked by a pharmacist also discharge summary received did not list current medication .
105	Ward [number] stop raised for patient on [name] unit . Mirabegron and Rivastigmine ordered , label for mirabegron was applied to the Rivastigimine box and vice versa . Error discovered on the ward , as far as we are aware both medications were given correctly on the ward despite the incorrect labelling . .
106	A patient handed in a prescription but on checking we found out it was for a wrong patient . The doctor at the clinic had taken a prescription printed out for a different patient and given it to another . .
107	Please reduce mirabegron dose from 50mg to 25mg due to impaired renal function . [reference number] - suggestion based on recommendations in renal drug handbook continue version .
108	The GP had made a home visit , the patient&#39 ; s [relative] wanted Mirabegron to be prescribed which was done on a hand written script . When the GP was writing up the notes later , noticed contra indication alert for this drug came up as the patient&#39 ; s

	GFR was 13 and also had a permanent catheter which was unlikely to be of benefit . The Dr telephoned the patient&#39 ; s [relative] and told [relative] to tear up the prescription and to stop the medication and amended the patient&#39 ; s notes . .
109	Patient refusing solifenacin as causing a severe dry mouth - already prescribing mirabegron an alternative for overactive bladder therefore solifenacin stopped by pharmacist .
110	Regular meds need prescribing : Fostair 100 / 6 MDI 2 puffs BD Ranitidine 150mg BD Trimethoprim 100mg ON (to restart once treatment Abx stopped) Mirabegron MR 50mg OD Salbutamol MDI 2 puffs prn .
111	Noticed by staff nurse and reported to pharmacy . Mirabegron MR 25mg on label 50mg in box . Tablets removed from foil strip indicating been given some doses of 50mg . 2 boxes in cupboard (some containing correct tablets . Unclear if or when [patient] has had incorrect dose . 7 tablets removed from strip . Mirabegron 25mg MR prescribed on medication chart . .
112	Oxybutynin stopped on admission and switched to mirabegron on TTO , however not prescribed on drug chart . Please review if mirabegron is to be initiated . .
113	Severe interaction between mirabegron and ropinarole - &gtconfusion , hallucinations , sleepiness .
114	Wrong label on container .
115	Multiple patient needing medication on their drug charts - Meropenem , Alfacalcidol , Sevelamer , Mirabegron MR , etc . Advised by CSP that pharmacist would visit the ward after [time] and the items should be requested from the pharmacy team . They called pharmacy repeatedly and knocked on the door but no response . .
116	The TTo for this patient contained 50mg mirabegron MR instead of 25mg .