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6 December 2016

[redacted]

By email
[redacted]

Dear [redacted]

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

I refer to your email of 8 November 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:

"Please could you answer the following questions for the 2014/2015 and the 2015/16 financial year.

1. How many reports of medication errors did you receive where the degree of harm was recorded as death? Please provide a breakdown of where these incidents happened, (eg acute care, mental health etc).

2. For each incident please provide a summary showing the name and quantity of the drug they should have received and the name and quantity of the drug they did receive. I also require a medication incident category for each incident (eg: wrong dose, monitoring, omitted and delayed medicine). Please also provide me with a brief summary of the incident [redacted]*. Please note that I do not require the name of the venue, staff or patient".*

Decision

NHS Improvement holds the information that you have requested.

NHS Improvement has decided to release the information that it holds.

The information we hold 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 medication incidents reported as occurring between the dates 1st April 2014 to 31st March 2016 if these had been uploaded to the NRLS by 15th November 2016.

In response to part 1 of your request Table 1 below provides a breakdown by financial year the number of reports of medication errors reported to the NRLS where the degree of harm was recorded as death by the original reporter.

Table 1 - Medication incidents where the degree of harm was recorded as death, by care setting

Care Setting where incident was reported to have occurred	Financial Year 2014/15	Financial Year 2015/16	Total
Acute (non-specialist trust)	40	54	**94**
Acute specialist trust (including acute specialist (children))	1	0	**1**
Ambulance	1	0	**1**
Mental health	3	0	**3**
NHS Community trust	1	2	**3**
Primary Care	1	8	**9**
Wales LHB	0	1	**1**
Total	**47**	**65**	**112**

In response to part 2 of your request the 112 incidents identified in Table 1 were clinically reviewed in order to extract the information you requested. Following this review, 89 of the 112 incident reports included one or more of the following types of information; the incident description; the name and the quantity of the medicine that should have been received; the name and the quantity that was actually received; and/or the medication error type. Annex 1

below provides a summary of the 89 patient safety incidents reported as occurring between April 2014 and March 2016. The incident description provided is verbatim and has been redacted to ensure that no information can potentially identify those involved with the incident.

Please note that of the 23 incidents that were excluded from Annex 1, 9 of these incidents appeared to describe adverse or allergic drug reactions in apparently appropriately prescribed and administered medication and 13 incident reports provided no information relating to the medicine name involved and one incident was a case of patient self-harm.

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 and the attached information 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 Patient Safety Team

Annex 1

This is a summary of patient safety incidents reported as occurring between April 2014 and March 2016 where these have been recorded as medication errors and include: the name and quantity of the drug the patient should have received and the name and quantity of the drug they did receive; the medication incident category for each incident (eg: wrong dose, monitoring, omitted and delayed medicine); and a summary description of the incident as reported by the original reporter.

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
I have been advised on [date] of a dispensing error and that the patient had died , but it is not clear the extent to which the error contributed to the death. - Ensure that similar boxes of different medications from the same manufacturer are not mixed on the dispensary shelves. - Identify different strength of the same medication and mark the shelves with red sticker to alert staff to make the correct choice. Ensure all the above actions are carried out and acted upon.	naproxen AND/OR phenoxymethylpenicillin (unclear)	naproxen AND/OR phenoxymethylpenicillin (unclear)	Not stated	Not Stated	Wrong drug / medicine
Patient seen by a nurse (who is a prescriber) had written a script for diamorphine - we only became involved as their relative could not find a chemist stocking this. The relative had told the nurse (not the usual one for the patient) that they were on 800mg of oral morphine as zomorph plus Oramorph top ups.This obviously was not checked at the time - as	Morphine sulphate	Morphine sulphate	80mg (40mg twice daily)	800mg nearly prescribed in error before intercepted	Wrong / unclear dose or strength

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
they were actually on 40mg bd ie 80mg daily of Zomorph. The nurse was about to write up 10x the required dose. The GP rectified this and made sure the is the correct doses - but a very potential near miss which would have had been devastating. As the nurse was a nurse prescriber and had written their own script I am not sure how we could avoid this happening again.					
Elderly patient admitted to hospital &quote, gone off feet; They died in hospital and the cause of death is recorded as gastrointestinal haemorrhage. Patient was prescribed dabigatran for atrial fibrillation. The BNF states that it should be avoided if eGFR&lt ; [on date] the eGFR was 24. Despite this their dabigatran had not been stopped.	none	dabigatran	none	Not Stated	Contra-indication to the use of the medicine in relation to drugs or conditions
A patient we were seeing for Warfarin from another practice – [name] died from and ischaemic stroke - in [name]Hospital [place]. Our Warfarin Nurse was aware that they had been admitted in [date] and paused their on INRstar but when they had seen no INR results added alerted me on [day]. I asked their own practice for information and they emailed me information at [time &day] to show the letter	Novel oral anticoagulant (in-specified)	warfarin	Not stated	Not Stated	Other

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
for [name]. Usually they send an email to all staff when a patient dies and then would have realised they were our warfarin patient and sent us information but on this occasion it did not work. The patient with co - morbidities and a TTR of just [figure] - we had considered shifting them onto a NOAC as their INRs were labile. My Nurse had pointed this out to me on a couple of occasions and in retrospect the learning is that we should have changed them sooner. Patient was unwell and eating just one meal a day on occasions. Not shared or discussed with family - as not our patient.					
Mispick - picked stock for shelf above normal location. Apologised and replaced with correct medication. checked to make sure stock was on separate shelfs.	Not stated	Simvastatin	Not stated	Not Stated	Wrong / unclear dose or strength
Patient transferred from [name] hospital on [date] , registered with practice on [date]. No Previous medical history given except discharge sheet (relapse of psychosis listed) and request to provide Flupentixol injection on [date]. Referral was made to mental health team who normally undertake this service , including prescribing. Due to time scales , mental health team asked GP to prescribe. Information for prescription	flupentixol	flupentixol	20mg	200mg	Wrong quantity

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
taken from faxed discharge sheet - GP thought it read 200mg when it actually read 20mg. 200mg within normal dosing range so not flagged by GP system or CPN who administered injection. Error noted the following day when CPN spoke to staff at [name] Hospital. GP , Home and local hospital contacted , patient admitted for observation and discharged the same day. CPN team monitored patient on a daily basis until [date] when the patient was seen by the Nurse Clinician at the Practice and admitted to [name] Hospital. Patient reported to be very sleepy and hallucinating. Patient discharged from hospital on [date] to Nursing home (residential home bed) following treatment for dehydration and Acute kidney injury. Nursing home staff requested visit on [date] with concerns that patient was not eating & ; reluctant to take fluids. Agreed action was to push fluids and monitor. Patient visited again on [date] and [date]. Staff at the home agreed to one to one nursing on [date] to encourage hydration and continuing care on [date]. GP advised hospital admission if fluid uptake low, noted family did not wish patient to be admitted. Patient passed away on [date]. The Practice have undertaken an investigation and discussed the details at a significant					

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
event meeting. The report and action are available to email. The GP & ; Practice Manager will meet with the relative this week to explain matters further. Duty of Candour acknowledged.					
CARE SERVICES RECIEVED CALL ON [date] AT [time] FROM REPRESENATIVE OF HOME SAYING THAT they HAD BEEN DRIVING AROUND TO TRY AND OBTAIN END OF LIFE MEDICATION FOR A PRESCRIPTION they HAD ON their PERSON. DISPENSER EXPLAINED THAT WE WOULD SOON BE CLOSING AND REPRESENTATIVE ASKED IF WE COULD TAKE THE MEDS REQUIRED OVER THE TELEPHONE AND COULD WE COLLECT RX FROM THE HOME THE FOLLOWING MORNING THE REPRESENTATIVE SIAD THAT THEY DID HAVE MEDICATION IN THE HOME AND THAT THE PATIENT MIGHT NOT LAST THE NIGHT. DISPENSER TOOK THE ITEMS OVER THE TELEPHONE FROM THE REPRESENTATIVE AND WENT TO ORDER THE ITEMS WITH THE PHARMACIST. THE MIDAZOLAM GIVEN OVER THE TELEPHONE WAS 5MG / 1ML. THE PHARMACIST 5MG / 1ML WAS NOT DONE. DISPENSER COULD NOT RING REPRESENTATIVE BACK	midazolam	none	5mg/Ml (unclear)	none (unclear)	Wrong / unclear dose or strength

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
BECAUSE SHE WAS IN THE CAR.. DISPEnSER CHECKED DISPENSARY WITH A TEAM MEMVER AND THERE WAS MIDAZOLAM IN THE CD CUPBOARD. CARE SERVICES MANAGER AND TEAM CAME IN THE NEXT DAY [date] AND THE PRESCRIPTION HAD BEEN FAXED OVER. AND COMMUNICATION BOOK AND A PAPER MESSAGE HAD BEEN LEFT OPEN FOR THE TEAM TO SORT THE NEXT DAY. CARE SERVICES MANAGER CHECKED THAT THE COLLECTION WAS ON [name] FOR THAT MORNING AND READING THE MESSAGE LEFT IT DID STATE THAT THE HOME MAY BRING THE RX INTO THE STORE. MID MORNING A REPRESENTATIVE FROM THE HOME CALLED TO SAY THAT THE RX WAS STILL AT THE HOME. CARE SERVICES MANAGER SAID THE DRIVER DOES KNOW they have TO FETCH THE RX AND AFTER CHECKING TOLD THE HOME IT WOULD BE COLLECTED SOON AND THEY WOULD STILL HAVE DELIVERY THE SAME AFTERNOON. THR REPRESENTATIVE WAS OK WITH THIS AND SAID TO THE CSM THAT SHE COULD NOT UNDERSTAND WHY IT HAD NOT BEEN TAKEN TO THE EMERGENCY					

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
CENTRE ON FRIDAY TO BE DISPENSED... THE PRESCRIPTION CAME TO US AT [time] DUE TO THE DRIVER RUNNING LATE. DISPENSER DISPENSED THE LEVOMEPROMAZINE IN THE [name] AND THEN TOOK THE RX DOWNSTAIRS TO THE DISPENSARY TO DISPENSE THE CONTROLLED DRUGS. AT [time] THE [name] HAD A TELEPHONE CALL FROM THE DISPENSER FROM DOWNSTAIRS TO SAY THAT THE MIDAZOLAM IN THE CD CUPBOARD WAS 2MG / 2ML AND 5ML / 5ML HAD BEEN PRESCRIBED. THE CSM ASKED THE DISPENSER THE PHARMACISTS COULD 2MG / 2ML AND MAKE A CALCULATION. THE ANSWER WAS NO. CSM ASKED IF THE PHARMACIST COULD CALL THE HOME AND WAS TOLD THAT ONE PHARMACIST HAD GONE AND THE OTHER WAS BUSY. CSM PICKED UP THE TELEPHONE AND CALLED THE HOME AT [time] AND SPOKE TO THE REPRESENTATIVE SHE HAD SPOKEN TO EARLIER. THE CSM EXPALINED TO THE REPRESENTATIVE THE PHRMACISTS SITUATION AND ASKED THE REPRESENTATIVE IF they WANTED US TO SUPPLY THE DIAMORPHINE AND LEVOMEPROMAZINE OR DID thry WANT					

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
ME TO SEND A DRIVER WITH THE PRESCRIPTION BACK , AT FIRST they DID NOT KNOW WHAT TO DO BUT DECIDED TO HAVE THE PRESCRIPTION BACK AND TAKE IT TO THE EMERGENCY CENTRE THEY ALWAYS USE. CSM ARRANGED FOR A DRIVER TO COME STRAIGHT AWAY AND THE DRIVER LEFT [name] WITH THE RX AT [time] AND IT WAS DELIVERED TO THE HOME SO AS THE REPRESENTATIVE COULD TAKE IT TO BE DISPENSED AT [time] WHEN they GET PICKED UP FROM WORK. [date] THE MANAGER CALLED INTO THE [name] AT [time] AND ASKED FOR [Staff Name] TO GET IN TOUCH WITH them AS SOON AS POSSIBLE they WANT TO TALK ABOUT THE PATIENT CONCERNED... MANAGER CALLED THE HOME MANAGER BACK AS SOON AS SHE CAME FROM their MEETING. THE HOME MANAGER SAID THAT they AND their STAFF WERE DRIVING AROUND [place & day] BECAUSE WE HAD LET them DOWN WITH THE MEDICATION FOR AN END OF LIFE PATIENT they SAID they HAD OBTAINED IT FROM THE HOSPITAL BUT BY THE TIME they HAD GOT BACK TO THE HOME WITH IT THE PATIENT HAD PASSED AWAY AND IT WAS OUR FAULT , they SAID they are					

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
GOING TO REPORT IT AND TAKE IT FURTHER. THE [name] TRIED TO TALK THROUGH THE SERIES OF EVENTS LEADING UP TO [day] BUT THE HOME MANAGER PUT THE [name] ON TO THE REPRESENTATIVE FROM SAT TO TALK TO THE [name] WAS GOING THROUGH EVERYTHING WITH THE REPRESENTATIVE WHEN THE HOME MANAGER CAME BACK ON THE TELEPHONE AND SAID DONT BLAME ME I WAS THE ONE WHO CALLED ON [day] AND GAVE THE MEDICATION OVER THE TELEPHONE.					
Patient visited [dept.] on [date]. Medications were copied from a discharge summary from [year]. The GP has re - prescribed these medications. This has resulted in the patient presenting with bradycardia , hypotension and hypothermia. Patient was admitted to ITU but subsequently passed away on [name] ward. Raised as SI , acute medicine asked to provide an investigator as discussed at governance meeting on [date]. [Staff] will feed back to [staff] about copying and pasting old drug history. Medication history documented in notes must be up to date. If not possible to establish , check on View / recent clinic letters.	none	atenolol	none	Not Stated	Wrong drug / medicine

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
Patient was admitted on [date] with shortness of breath. Patient was found to have aortic stenosis and paroxysmal AF. Patient was prescribed treatment dose dalteparin on [date]. Throughout admission they had regular U&E testing ; eGFR was <30ml / min throughout admission. On [date] the patient had clotting studies done which showed prolonged PT and APTT. Patient developed dizziness and diplopia on [date & time]. I was called to see them overnight at around [time] and attended at around [time]. Patient had neurological signs suspicious of a brainstem lesion. Patient had urgent CT and discussion with haematology and stroke. CT confirmed intraventricular haemorrhage with evolving hydrocephalus. Patient was discussed with NHNN for urgent neurosurgery but declined due to comorbidity. Patient had a cardiac arrest around [time] and died , presumably from the intracranial haemorrhage.	Not stated	dalteparin	Not stated	Not Stated	Contra-indication to the use of the medicine in relation to drugs or conditions
On [date & time] , when I started my shift was told by the nursing working at night that patient cannula was not working during the night. Staff nurse said that they flushed the line changed pump but still not working. They also said that they contated the on call doctor to re - cannulated patient during the night but they said they were unable to	0.9% Normal Saline	none	1000ml	none	Omitted medicine / ingredient

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
do so at [time]. As I was doing my medication around , I was contacted buy my [staff member]. They found combi lock attached to the cannula and the given said attached as well. They said that is the reason why the cannula was not working. [staff member] called and as well showed the problem. Nurse in charge advise flush the cannula which I did and the cannula started working straight way than patient starting having IV Fluids. I so patient fingers looking blue checked their blood pressure it was around 85 systolic Sats 77 , irregular heart rate and resp around 11 patient mews 13,14. Doctor contacted as well as outreach nurse. Patient put on 15 litres oxygen , blood gas done. On call doctor unsure whether to seek help from medical doctor. Family contacted by staff nurse [Staff Name] to came to the ward as patient was very unwell. Registrar from [department] came to the ward to see patient. Advise to do a ECG , IVAB which I did speed up fluids as patient was dehydrated , requested portable X RAY. Nurse spoke to the family on the ward, family was are patient was not for resuscitation. Nurse asked medical registrar to speak to family and they said under condition of their relative they agreed with the decision. Registrar from medical ward said patient					

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
would benefit if they had the iv fluids night before. Patient was on acute renal failure as well as dehydrated. OUTREACH nurse advise nurse to put incident form. staff to be extra vigilant especially in poor lighting such as during the night. All staff involved counselled.					
Weekly team meeting to discuss patients. We discussed the death of a patient who had extensive poor prognosis relapsed germ cell cancer and had received initial induction chemotherapy on [date]. Performance status was poor and treatment schedule had been modified to reflect this. Patient deteriorated and died with renal failure and neutropenia. Earlier in the week I had discussed with the ward medical staff about events leading up to the patient's death and had asked that the case be referred to the coroner for a post mortem. At the team meeting we did not have access to the patient's case notes but during our discussion. I looked at the chemotherapy prescription allocated on chemocare and was concerned that the treatment prescribed contained incorrect doses of carboplatin. I have not been able to confirm if this was administered or not which makes reporting /risk assessment levels uncertain at this stage. At present the	carboplatin and Etoposide	carboplatin and Etoposide	Carboplatin - 1 dose on day 1 and etoposide - 100mg/m2 x 3 doses	Wrong dose not specified	Wrong frequency

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
full details of the incident are not known and it is unclear whether or not an incorrect dose of chemotherapy was administered. The case had been referred to the coroner prior to identification.. Chemocare prescription added to incident. confirmation from [staff member] that the intended chemotherapy was carboplatin AUC4 x 1 dose on day 1 and Etoposide 100mg/m2 x 3 doses. Chemotherapy prescription differs to this intended regimen.					
Drug administration error during resuscitation of critically ill patient contributing to deterioration and death. Labetolol hydrochloride 200mg given instead of hydrocortisone 200mg IV Caused bradycardia leading to asystolic arrest despite attempts to reverse effects and external pacing. Patient was declining rapidly despite treatment prior to this incident which occured during a complex resuscitation episode.	hydrocortisone	Labetolol hydrochloride	200mg	200mg	Wrong drug / medicine
A palliative patient required subcut morphine and midazolam. Another patient also required analgesia. Both had the same first name. 2 registered nurses checked the CD. On going to administer the drug and complete the check , nurse 1 was	none	morphine and midazolam	none	Not Stated	Wrong drug / medicine

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
interrupted by pharmacy. There was a miscommunication and nurse 2 went to administer the medication without the second checker and gave the drugs to the wrong patient..					
Patient admitted post op following open mesh repair of right obturated hernia done on [date]. PMH of dementia, valve procedure, diabetes , HTN and Osteoporosis Developed post op Ileus and aspirated pneumonia. desaturations on air requiring Oxygen for support and Chest physio and suctioning. Prescribed oral sando - k to be given , [staff member] prepared and administered oral sando k via PICC line (intravenously given oral medications). Patient became un responsive , student nurse called the staff nurse who administered the Medication. Doctors on the ward at the time..	sando - k via enteral route	sando - k via PICC line	Not stated	Not Stated	Wrong method of preparation / supply
Diagnosis of CA bronchus and cerebral metastases established during in - patient stay on ward during IP stay on [dates]. Started on 16mg dexamethasone. No documentation in notes of any instruction to wean dose. Involvement of specialist nursing team at this point would be usual practice , but there is no evidence in the	dexamethasone	dexamethasone	16mg once daily (to be weaned down after a few days to a maintenence dose of 4mg-6mg once daily).	16mg once daily for five weeks.	Wrong frequency

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
notes that a referral has been made. Therefore still taking 16mg dexamethasone five weeks later when first seen by me in [name &date]. Usual practice would be to commence weaning dose down after a few days. Maintainence dose of 4 to 6 mg usually required. In my [department] the patient clearly had severe steroid - induced proximal myopathy. More importantly they were short of breath , desaturating , and had right - sided thoracic pain. Admitted via A / E directly from my [department]. CXR confirmed R lower lobe pneumonia. Died of sepsis within 24 hours , after failing to mount an adequate white cell response. The continuing high dose dexamethasone would have been directly immunosuppressant, and also caused high BMs , which have an adverse impact on prognosis in sepsis. This incident is being considered for investigation under the SI process at present based on the possibility of harm caused by the ongoing dexamethasone treatment. Summary of SI investigation There was no clear plan for the length of Dexamethasone course in the notes The [staff member] who wrote the TTO was unfamiliar with the patient and prescribed a 14 day course with the request this was continued by the GP The GP surgery added this to the repeat					

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
prescription template and issued 2 further supplies The patients review in clinic was delayed , and then their appointment was rearranged. Discharge of patients on ongoing steroid treatment without a plan to reduce must be avoided. Guidance to be developed for medical and pharmacy staff as to suggested doses and course length for steroids Prescribers to document indication and course length on all prescriptions for corticosteroids GPs to be advised not to routinely add corticosteroids to repeat prescription template.					
Patient admitted to [department] with Myasthenia Gravis on [date] previously been in [department] and their medication Pyridostigmine was increased from 60mgs to 80mgs by [staff member ant time] , this was then ordered by the nursing staff in [department]. Pharmacy did not let the medical team (know) that you can only get 60mgs tablets & tried to order liquid form , communication failure by Pharmacy. Patient passed away during the night due to organ failure ,. Full incident investigation will be completed.	pyridostigmine	none	80mg	none	Omitted medicine / ingredient
Patient admitted on [date] under [department] who deemed no [departmental]l input required and	warfarin	warfarin	Not stated	Not Stated	Mismatching between patient and

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
transferred care to [Staff Name]. During clerking , on admission , clerking Doctor wrote / prescribed Warfarin on " regular side " instead of " anticoagulant " on the drug chart. Therefore Warfarin has been given regularly without INR being checked prior to administration. Nursing staff has been administering Warfarin daily without doctor prescribing. Pharmacy has not noticed the mistake either. On the [date] , on called doctor was called by nursing staff to check / prescribe warfarin , doctor came and prescribed usual dose of Warfarin , unable to find a recent INR. On the [date] patient developed a stroke resulting from an extensive intracranial haemorrhage. INR was 7,2. Patient currently very unwell ; under the care Stroke team.					medicine
Patient admitted with a right nof at [time] , xray requested and bloods and ecg done. In pain and was given morphine 10mg iv at [time] as per hospital policy. Patient still complaining of 8 out of 10 pain post injection. Moved to [department] and handed over to nurse who was looking after. Time Nerve block given to patient. Doctor still with patient at [time]. Patient found at [time] unresponsive and crash bell pulled and cpr commenced.1 dose of adrenaline after first two minutes cycle.	Not stated	morphine and un-specified 'nerve block'	Not stated	10mg and 'nerve block' (dose / strength not stated)	Patient allergic to treatment

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
Cardiac output obtain at end of second two minute cycle. no respiratory effect.4th on call anaesthetist bleeped and patient moved to resus. 24 hour report completed by ED consultant and SI investigation commenced..					
Massive GI haemorrhage on [ward 1] [patient] 2 weeks post small bowel resection for [disorder] related stricture. Brief post op ITU stay. Transferred to [ward 2] for ongoing recovery. Dropped BP and became hypoxic so transferred back to [Ward 1]. Seen by Med SpR & Diagnosed as having likely PE. Therapeutic dalteparin started. CTPA requested but deferred until the morning. I was called to See the patient following a bout of haematemesis & malena. The patient quickly decompensated and arrested. I requested protamine - no staff available at the time knew what this was & no one (including me) knew where to locate it. The Crash bell was pulled , runners sent for blood and a 2222 put out. Assistance arrived quickly and in good numbers. As team numbers increased , so leadership of the situation decreased as multiple people started attempting to make suggestions and run the situation. Anaesthetic support arrived and the patient was intubated. A time keeper	protamine	dalteparin	Not stated	un-specified treatment dose	Omitted medicine / ingredient

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
was appointed. ROSC was attained after 10 minutes. The surgical SpR had attained a slot in theatre for immediate OGD. Transfer was delayed by difficult IV access. [staff] wanted to transfer immediately to theatre with the one pink cannula whilst other people attempted to delay this and insisted on further attempts at cannultion. A cannula was inserted into the Right femoral vein. It was assumed that this was a vein. No blood gas was run off the cannula to confirm its location in the femoral vein. It did not occur to any team member (including me) to attempt IO cannulation. I have performed IO cannulation a number of times and am disappointed that I over looked this. It would have sped up transfer time. The patient arrived in Theatre making respiratory effort but tolerating the ETT. It was decided that the decision to proceed with OGD should be questioned in the patients best interests. The surgical consultant arrived and a team decision was reached to not intervene given the patients age and significant co-morbidities.					
Patient with chronic lung disease admitted with cough and SOB. Following areas of management likely to have contributed to patients death : 1. Noted to be hypoxaemic on admission but no ABG performed and oxygen not prescribed 2. Hypercapnic and	Not stated	un-specified antibiotics	Not stated	Not Stated	Other

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
drowsy overnight due to high flow oxygen 3. CXR not performed for [hours] after admission despite diagnosis of CAP 4. Seen on [Ward] - incorrect antibiotics prescribed for AECOPD rather than CAP. No assessment of gas exchange. 5. Further developed acute type 2 respiratory failure. Decision to start NIV in [Unit] but no escalation in IPAP , therefore patient profoundly acidotic for at least [hours].					
I attended an arrest call on [Hospital Ward]. Patient was peri - arrest with apparent septic shock. Patient had not received antibiotics since admission ([hours] before). Full cardiac arrest team not available (anaesthetic SHO did not receive bleep) but this did not negatively impact on arrest. Later anaesthetic SHO had to leave to attend paediatric arrest and no other anaesthetic cover available due to other commitments and not able to return until patient re - arrested.	un-specified antibiotics	none	Not stated	none	Omitted medicine / ingredient
Patient admitted on [date] with general deterioration ?cause. Septic screen performed and CT head - [date] and MRI Head [date] Ruled out acute bleed or subdural. Dalteparin was initially withheld until CT and MRI , LP delayed due to no INR and performed on [time/date] with the plan to start dalteparin on [date]. However plan to start dalteparin had not been	dalteparin	none	un-specified prophylactic dose	none	Other

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
documented in the notes or communicated to on call team. Very busy week [date] and decision R. E dalteparin was not reviewed, VTE had already been completed - no flags raised. SHO away [date]and [date]. Consultant came to the ward at [time/date] to ask junior team to prescribe dalteparin as CTPA verbal report had shown bilateral PE. [Staff] went to patient to find weight of patient and nursing staff were with patient who alerted medical team the patient had become non - responsive , CPR started immediately , MET call made.					
Dose of rivaroxaban for treatment of acute pulmonary embolism not administered. From a ward perspective , all staff receiving point of care education regarding riveroxaban. 70% of staff trained as of today's date with signatures obtained. Discussions with staff about using defer option on JACS rather than drug unavailable..	Rivaroxaban	none	Not stated	none	Omitted medicine / ingredient
The patient was prescribed and administered the excessive amount of Dalteparin for a systemic anticoagulation. This resulted in a severe GIT bleed , which entailed the death of the patient.	dalteparin	dalteparin	Not stated	Not Stated	Wrong quantity
Patient had a [organ] biopsy on the [date]. Following this , and when the patient returned to the ward , a dose of daltaparin 5000units was administered later that	Not stated	dalteparin	5000units	5000units	Contra-indication to the use of the

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
evening (prescribed for [time] although actual time given is for further investigation). The patient reported abdominal pains after having the daltaprin. Condition deteriorated , peri arrest occurred.					medicine in relation to drugs or conditions
Gentamicin has been given at [date/time] and again on [date/time]. Level were taken 12 hours after [date/time].	none	gentamicin	none	Not Stated	Wrong / unclear dose or strength
Patient attended ED via ambulance on [date/time] following a fall. The patient had a cut to their ear which was stitched. A fractured right humerus was confirmed by xray and POP applied. Patient was referred to Orthopaedics who advised to discharge and arrange Fracture Clinic appointment. Whilst in the department the patient began to vomit. No insulin was prescribed in ED. Admitted to [Unit] at [time] for investigation. Previous [medical history]. Patient managed own insulin administration as gave dose depending on blood glucose levels. [blood glucose reading] on admission. Further vomiting on the ward overnight. Patient commenced on intravenous Pantoprazole. Patient nil by mouth and sliding scale commenced. [date] Seen on Post Take ward round by Gastroenterologist. Gastroscopy arranged. Gastroscopy performed at [time] which showed oesophagitis and hiatus hernia.	insulin, pantoprazole	Insulin sliding scale ; Humalog; Levemir ; pantoprazole	Insulin sliding scale initially and then patient self administering Humalog and Levemir, patoprazole dose not stated	Insulin sliding scale dose not specified; Humalog 15 units and Levemir 8 units; pantoprazole dose not stated.	Omitted medicine / ingredient

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
Doctor informed of results. Advised to take down sliding scale as can eat and drink normally. Self-administration of insulin was discussed by doctor with patient , staff nurse and sister. All happy for patient to self-administer. Insulin locked away and self-administered under supervision. No documentation of insulin administered for the rest of the day. Sliding scale had been removed after the gastroscopy.[blood glucose reading] at [time]. No insulin given. Rechecked at [time] [blood glucose reading]. [date] Patient self-administered 15 units of Humalog and 8 units of Levemir prior to breakfast. [blood glucose reading] Reviewed by SpR at [time]. Patient has drug induced AKI. Plan monitor input / output , USS abdo and renal tract , U&E , IV fluids over 8 hours , encourage oral fluids. Documented that patient self-administered 32 units of insulin at [time]. [Blood glucose reading]. Transferred to [Ward]. USS performed. Reviewed by consultant at [time]. Plan home if USS normal with PPI cover. USS results Normal appearance of kidneys. Creatinine improving. Plan Home tomorrow if creatinine improved. [time/date] documented by staff that patient becoming increasingly confused. [Blood glucose reading]. Unable to pass urine , bladder					

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
scan completed. Message put on [abbreviation] to review. [time] Ketones [time] Noted that medics prescribed IV fluids whilst on [Unit] but not administered. Patient had pulled out cannula earlier. To ask [Abbreviation] to review when they arrive. [Time] Reviewed by [staff]. A - E assessment. Patient mumbling and answering inappropriately to questions. Diagnosis Confusion secondary to hyperglycaemia ?DKA. Blood tests taken. [time] [staff]. [test] indicates severe DKA. Treatment prescribed for DKA as per Trust protocol. [time] Patient arrested. Prolonged resuscitation. Return of spontaneous circulation at 26 mins. Re - arrested at 32 mins , 50 mins and 60 mins. Transferred to Critical Care at [time]. CT scan performed on [date] showed hypoxic brain injury. Discussed with Neurosurgeons who said is not survivable. Critical Care team discussed findings with family and withdrawal of active treatment. Patient died at [time/date].					
Patient was discharged from [Hospital] on [date] and a referral was faxed to anti - coagulation from the ward the patient was on warfarin. Anti - coag staff arranged an appointment for [date] with a medicar to collect the patient from the address on the faxed referral. The referral indicated the patient was not going to the home address	warfarin	warfarin	Not stated	Not Stated	Other

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
but to an off - site rehab bed and they had hand written the address in the box provided on the form. On [date] when the medicar arrived at the address it turned out to be the patient's home address and patient was not there. Anti - coag staff then liaised with the ward to find out the destination of this patient on discharge and due to not being able to get further transport and in light of the information written on the referral form it was assessed as reasonable to provide dosing information to the carers at the off - site rehab home for over the weekend based on the INR results and previous doses. They were informed to give the patient 0.5mg per day and that that anti - coag staff would arrange for the community phlebotomist to attend on [date] to take bloods for an INR check. The lady was however admitted to A&E on [date] before any bloods were taken with an upper GI bleed and sadly the patient died in vascular angio later the same day. The initial issues raised as concern were: The incorrect discharge address had been put on the referral form and there was no information relating to the fact that this lady was not stable was on the referral form , as if the anti - coag staff had been aware of this on the [day] when the transport issue had emerged a different decision may well					

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
have been taken with regard to the patient's management over the weekend.					
Patient admitted with haemoptysis and respiratory failure The patient had a history of AF and was anticoagulated with warfarin. INR on arrival was 3.4. The SpR on call took advice from the haematology consultant on call about reversing the anticoagulation. The SpR documented the advice to give octaplex and vitamin K. The octaplex administration is documented. There is no record on the prescription charts of vitamin K being administered. The INR did not fully reverse. The patient deteriorated at [time] on [date] and died a short time later. The POSSIBLE failure to administer Vitamin K MAY have contributed to the patient's death. This possible omission was not noticed until notes review for the preparation of a coroners report.	vitamin K	Octaplex	Not stated	Not Stated	Omitted medicine / ingredient
Respiratory Arrest , Patient had been confused overnight requiring administration of sedation. Pt initially found to be profoundly hypoxic then lost respiratory effort.	Not stated	Un-specified sedation	Not stated	Not Stated	Other
Patient found with BM of 1.1 making little respiratory effort. Cardiac arrest call put out. Issues : - Suction required for intubation , found to be not set up correctly for immediate use as per Trust policy. Patients own meds including insulin pens	Not stated	Insulin, 50% glucose	Not stated	200mls of 50% glucose	Other

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
found in unlocked POD draw. Patient required nearly 200mls of 50% glucose to return BMS to within normal limits , therefore assumption by drs that the patient may have been self-injecting insulin. Patient required intubation and transfer to [ward].					
[Ambulance] brought Patient to A&E who was then admitted [time] as a general medicine Patient with Haematology on previous admission. Patient had a cardiac arrest @ [time] same day. PM report noted overdose of oxycodene as a cause of death.	Not stated	oxycodone	Not stated	Not Stated	Wrong / unclear dose or strength
Patient admitted to [Hospital] for neurosurgery on [date] in relation to a subdural haematoma. The patient was previously on long - term naproxen for arthritis together with omeprazole , and although the naproxen was restarted on [date] following the surgery , the PPI cover was not restarted until a month later on [date] following gastro advice subsequent to symptoms consistent with a GI bleed. Although an OGD performed the next day was not too concerning , the patient suffered a fatal cardiac arrest and GI bleed later that day and died.	Naproxen and Omeprazole	Naproxen	Not stated	Not Stated	Omitted medicine / ingredient
This patient was transferred from [Hospital/Ward] on the [date] , to [ward] at the [Hospital 2] at [time]. The patient had been admitted as an elective patient on the	hydrocortisone	none	Not stated	none	Omitted medicine / ingredient

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
[date] for an endoscopic trans nasal transphenoidal resection of a pituitary adenoma. PMHx : Dementia , Hypertension , hypothyroidism , secondary adrenal insufficiency , cataracts. The patient was noted to desaturate post op and was treated for a HAP , and transferred on the [time/date]. The patient was clerked in and post - taked on the [date]. The plans had been to get CXRs , bloods , endocrine opinions and an opthalmology review (as per neurosurgeons). An [Staff] also reviewed the patient on [date]. It was noted on the consultant wr on [date] that hydrocortisone was not given in the morning as it was being ordered from pharmacy. The patient received a dose of hydrocortisone in the evening. The patient spat out the hydrocortisone the following morning , and went to x-ray. On the return , the patient was noted to be unwell , and reviewed by the F1 who performed an ABG. Senior help was called and the patient arrested and the cardiac arrest team was called. The ABG BM was 0.8 with a lactate of 12.12. The patient had 12 minutes of CPR and a repeat ABG which showed the glucose to rise to 12 , lactate 16.81. A decision was made to stop CPR and the family / NOK were informed.					

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
This patient was taking warfarin due to an irregular heartbeat but was having difficulty with forgetting to take it (due to the onset of dementia. The patient saw their GP who put the patient on aspirin but patient was not taking this either so Clopidogrel was started at 75mg per day and the patient was referred to the [Hospital] to assess for suitability for warfarin replacement.. The patient was seen on the [date] and was found not to be suitable, therefore patient was put back on warfarin, continued to take Clopidogrel. The INR level should have been checked on [date] but this did not happen until the [date]. The result came back on the [date] with an INR of 10.1 , at which point the patient had presented at A and E and was admitted to [Ward]. The patient died later that night from a large intracerebral haemorrhage..	warfarin	warfarin and clopidogrel	Not stated	Warfarin not stated, clopidogrel 75mg per day	Other
Patient admitted to ward with a [fracture] on [date] and had operation on [date]. Following the operation the patient was taken back to ward and later developed Acute Kidney Injury and became Hypotensive and Metabolic Acidaemia. Patient was transferred to [dept] on [date/time] and sadly passed away [date/time]. This patient was given 2 x doses of Anti Hypotensive Medication whilst the patient was Hypotensive which could	none	diltiazem	none	2 x doses (un-specified)	Wrong quantity

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
have contributed to their demise and also said this patient will be having a Post Mortem and full Toxicology report to determine the cause of death.					
Patient admitted [date] with falls. Found to be in complete heart block. Cardiac arrest and resuscitation with temporary pacing. Patient died on [place number] days later. Patients complete heart block possibly secondary to combination of Atenolol and Verapamil plus potentiation of verapamil by clarithromycin.	atenolol	atenolol, verapamil and clarithromycin	Not stated	Not Stated	Contra-indication to the use of the medicine in relation to drugs or conditions
Pt had had previous cardiac arrest due to hypoglycaemia and was transferred to a nursing home for respite / assessment. Found on floor by carers so readmitted [blood glucose reading]. Medication prescription from home did not include insulin BUT did state diabetic on insulin in [Hospital] section. Previous TTO on CRRS had record of insulin and dose. Pharmacy check on morning after admission [date] appears to have used care home script only insulin missed. No insulin prescribed on admission. Has recorded pyridostigmine but none available for patient from admission on [date]to death on [date]. Unable to locate any BM chart from [ward A]. On transfer to[ward B] pt reviewed by consultant at [time] on [date] BM checked 26 noted to smell ketotic and VBG performed - severe	Insulin, pyridostigmine	none	Not stated	none	Omitted medicine / ingredient

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
metabolic acidosis glucose 29. Appropriate treatment for DKA initiated and diabetic SPr reviewed. BM chart shows rapid fall in BM and hypoglycaemia developing with BM 2.9 then 1.6 in last hours before death. DKA had resolved and variable rate insulin could have been instituted at [time]but decision not made until [time](at which time BM 1.6). No evidence that any treatment for hypoglycaemia other than stopping insulin infusion was instituted..					
Patient prescribed 50units Actrapid in 50%Glucose 50ml to be given over 30minutes. Infusion checked and given over 30minutes. On transferring out into majors it was noted that this dose of actrapid was incorrect. [Staff] aware , [Staff] aware , patient transferred back into resus. Half hourly BMs monitored. When error initially noted patients BM was in normal range. Patient had a low GCS on arrival into the department.	insulin and glucose	insulin and glucose	insulin quantity not stated; 50mL glucose 50%	50units Actrapid in 50%Glucose 50ml given over 30 minutes	Wrong / unclear dose or strength
Patient sent home on low molecular weight heparin to reduce risk of stroke post ERCP but readmitted [date] with likely biliary sepsis , ERCP related bleed and myocardial ischaemia. Patient died on [date/time].	Not stated	Low molecular weight heparin (unspecified)	Not stated	Not Stated	Adverse drug reaction (when used as intended)
patient on mexiletine for AVNRT. Counselled pre pregnancy and given data available from national teratology database.	none	mexiletine	Not stated	Not Stated	Adverse drug reaction

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
Foetus had severe early onset IUGR which it is possible was associated with the therapy and died at approximately [weeks].					(when used as intended)
Patient died from Pulmonary Embolism following #NOF.	dalteparin	none	5000iu	none	Omitted medicine / ingredient
Patient admitted with falls and confusion. ECG showed complete heart block. Noticed to have possible seizure activity. CT brain normal. Patient was given loading dose of IV phenytoin and was on cardiac monitor. 10 minutes after the infusion patient had an asystole cardiac arrest with unsuccessful CPR.	Not stated	IV phenytoin	Not stated	Loading dose (un-specified)	Contra-indication to the use of the medicine in relation to drugs or conditions
See mortality review on EPR - patient had perf DU following the use of high dose steroids with no PPI cover. Mortality review attached in documents.	omeprazole	steroid (un-specified)	Not stated	High dose (un-specified)	Omitted medicine / ingredient
Patient seen by [Staff] with severe abdominal pain. Referred to surgical team. They reviewed and asked for medical opinion. I gave medical opinion and advised to stay under surgical care. Patient Type 1 diabetic with complex history. Blood sugar in A E between 3 and 5. I advised surgeons to consider sliding scale insulin if patient is not eating but to hold off at present as blood sugars had been borderline low. I did not prescribe the patients regular insulin at this time as patient was under the care of the surgeons at this stage and I assumed	insulin	none	Sliding scale (dose un-specified)	none	Wrong frequency

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
that they had completed the wardex on clerking the patient. Later , the urology consultant reviewed the patient and referred back to the [Staff] who accepted the patient under medical team. Issues with where to place the patient as requiring high levels of analgesia including ketamine for patient's pain. Placed on surgical ward as a medical outlier so that patient could have patient controlled analgesia. Seen by support [Staff] and PCA prescribed. Next day pain control reviewed by [Staff] on call. Throughout this time blood sugars had been monitored by nursing staff intermittently. Documented that patient had refused a blood sugar at one stage. There is a blood sugar reading of 16 on [date] that was not escalated or acted on as far as I can tell. Unfortunately the patient was found to be semi - conscious and in diabetic ketoacidosis at approximately [time] on [date]. The patient was transferred urgently to HDU and reviewed by the ICU team. Despite treatment the patient had a cardiac arrest and died. The patient's regular insulin had not been prescribed.					
RCA Was completed on the [date] as this patient suffered a pulmonary embolism and died. It appears that the patient should have had 28 days of daltaparin post fracture protocol however patient only received 21	dalteparin	dalteparin	Dose un-specified, duration 28 days	Dose un-specified, duration 21 days	Omitted medicine / ingredient

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
days. Immediate post op dose was also omitted on anaesthetist instructions.					
I received an incident form [number] regarding an incorrect discharge summary on a deceased patient , on reviewing the notes in the clinical audit room it appears that the patient did not go home with extended apixaban as the [Staff] had requested.	apixaban	none	Not stated	none	Wrong quantity
The patient was admitted to [ward]with CAP a few days ago [date] and was medically fit to go home from mid week [date] last week. Patient was found to be in AF [date] and the anticoagulation was deferred. Patient was found to have rt. Sided weakness at [time] on [date] by nurses. The [Staff] was called to review the patient who rightly diagnosed a stroke and a CT was done at [time] which showed only an old stroke and no new ischaemic event. The SHO rightly identified the need for thrombolysis (within time window , NIHSS - 16 , moderate to severe stroke) but discussed with the registrar who decided against thrombolysis as the patient was [age](there no age cut off for thrombolysis now). There was no discussion with myself on call that night or the network stroke consultant. I reviewed the patient on [day], stroke was reconfirmed , NIHSS remained at 16 and we transferred the patient to Falcon [ward].	Thrombolysis (un-specified)	none	Not stated	none	Omitted medicine / ingredient

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
Patient has since aspirated and now prognosis is poor and may not survive the event. Patient eventually died on [date/time]. This was a clearly missed thrombolysis with the patient in AF as well which leads to much severe stroke. It is always debatable how much thrombolysis might have helped but it was the only therapeutic option available at that point.					
Patient admitted to emergency department at approximately [time] with possible acute coronary syndrome and treatment commenced for sepsis. Oxygen admistered in ED. Transferred to ward. The patient deteriorated over a number of hours and died at [time]. The doctor who went in to see the patient at time of death , reported that patient had been on receiving air instead of oxygen via face mask.	Oxygen	Air (medical gas)	Not stated	Not Stated	Wrong drug / medicine
Taken over shift from previous colleague regarding a patient referred to the outreach service at [time]. This patient developed symptoms suggestive of a stroke during the night , was escorted to CT by my colleague and were awaiting the CT report. The CT report shows the patient has had a large acute evolving infarct in the left MCA territory. At [time] handover my colleague asked me to clarify if Anti coag therapy should have been given. On reviewing the patient at [time] medication Apixaban (Anti	apixaban	none	Not stated	none	Omitted medicine / ingredient

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
coagulant) has not been given since the [date]. Within the notes this was to be omitted only on the [time/date] and [time/date] as per Consultant instructions as a bone marrow biopsy was to be carried out. This was to be recommenced again the [time/date]. This has not occurred. This patient was commenced on anticoagulation therapy due to history of chronic leg DVT.					
The patient was being checked frequently and in between the general ward checks. The patient was observed to be in deep sleep at [time] by 2 members of staff who were on duty. The Oxygen Saturation went down to 47.	Not stated	clozapine, lamotrigine, venlafaxine, lansoprazole, velafaxine, metoclopramide, zopiclone	Not stated	Not Stated	Mismatching between patient and medicine
Patient with lung cancer , had abnormal liver scan and LFT. Was on warfarin. Warfarin stopped for liver biopsy. After the procedure , warfarin restarted without realising abnormal LFT (a contraindication). Patient presented with cerebral haemorrhage due to INR &gt20 and died.	none	warfarin	none	Not Stated	Contra-indication to the use of the medicine in relation to drugs or conditions
Patient received chemotherapy on [date] , part of the supportive treatment was not prescribed or administered. The drug filgrastrim was not administered as per regimen on [date]. No blood monitoring has been found to suggest monitoring of blood levels (white cells). Blood test on [date]	filgrastim	none	Not stated	none	Omitted medicine / ingredient

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
shows neutropoenia when first GCSF (Filgrastrim) was administered [days] late.					
Patient received morphine with no obvious reason , resulting in respiratory depression and subsequent likely associated death. Surgical mortality notes review.	Not stated	morphine	Not stated	Not Stated	Other
Patient became agitated at [time] and attended to by S / N [initials] and agency nurse [initials]. Patient became hypotensive 55 / 48 and had a repeat vacant episode. Nurse whilst attending patient assumed a problem with the venflon and paused a pump infusing Noradrenaline at 16mls hour. Patient condition continued to deteriorate and CCP S asked to assess. Patient hypotensive , 44 systolic and unresponsive. ITU registrar attended [time] attempted to stimulate the patient and within minutes patient heart stopped. Declared dead at [time].	noradrenaline	none	16mls hour	none	Wrong quantity
Patient admitted on [date] with central chest pain and cough and fever. Background of pes with IVC filter and factor V laden syndrome for which normally on rivoroxiban. [date] rivoroxiban suspended for ctpa - clexane cover given (therapeutic) whilst PE ruled out [date] doctor (Staff) has documented to restart rivoroxiban - no stat dose prescribed. pharmacy advise reducing dose from 20 to 15mg. still not prescribed. [date] dose omitted as stated on	Rivaroxaban	none	Not stated	none	Other

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
EP med not available by [Staff, date] documented as med not available by [Staff, date] pt found on floor by bed with left sided weakness and slurred speech with GCS of 11 / 15. dr alerted and after ct head diagnosed with new MCA infarct. dr S. and advised for transfer to ward 8 stroke unit which took place at [time]. [date] rivoroxiban suspended in view of aspirin [Date] night shift - patient found unresponsive - GCS 3 - medical emergency put out - repeat ct shows huge MCA infarct with mass effect , midline shift and herniation family have raised concerns that drug omission has contributed to this.					
Patient prescribed Potassium Permanganate for soaking of legs , tablet was diluted , but i did not communicate to my fellow colleague that it was not for oral consumption. Patient drank approximately 120-150mls of diluted preparation.	potassium permanganate applied externally	potassium permanganate orally	Not stated	Not Stated	Wrong route
On reviewing medicine charts today [date] noticed that the medication for the patient , clobazam 10mg BD had been ordered by the pharmacist as clonazepam 10mg BD. As the OneStop order sheet had a clinical check on it , this was dispensed , accuracy checked and sent back to the ward as clonazepam. 7 doses of clonazepam were given instead of clobazam.	clobazam	clonazepam	10mg twice a day	10mg twice a day	Wrong drug / medicine

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
At [time] the patient was in the bathroom and the staff nurse was assisting the patient to wash. The patient appeared to be having a vasovagal episode so she asked for help. O2 was given at 15L via non rebreath mask. Patient was not responding so I fast bleeped the Dr and senior nurse , at this point the patient was breathing and had a pulse. Patient then stopped breathing so I put out an arrest call at approx [time]. CPR was commenced immediately.	Not stated	oxygen	Not stated	15Litres	Wrong drug / medicine
Cardiac arrest on the ward overnight following admission 4 hours previously. Admitting diagnosis was infection / sepsis with and unclear source. At the time of arrest it transpired that the antibiotics on admission 4 hours previously were not given. Resus call to ACU at [time] to a patient in full cardiac arrest. Patient had been admitted with a diagnosis of sepsis and was hypotensive on admission. During resuscitation it emerged that no antibiotics had been given , despite being prescribed , since admission to [Hospital] at [time] on [date](7 hours after flagged up as septic).	Antibiotics (un-specified)	none	Not stated	none	Omitted medicine / ingredient
Patient prescribed Potassium Permanganate Soaks. Agency RN doing the drug round had put the drug out ready to do the soak. Patient asked the Student Nurse on duty what the tablet was and she stated that she told the patient it was	potassium permanganate applied externally	potassium permanganate orally	Not stated	Not Stated	Wrong route

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
probably a vitamin and that the patient should take it at approximately [time].					
Patient who had a cardiac arrest whilst in the emergency department. Attended with [fractures]. Fascio - iliaca block given by [Staff] , further local anaesthetic given by orthopaedics for a haematoma block prior to manipulation. Patient has responded to resuscitation but is likely to have aspirated. No notes available from orthopaedics.	Not stated	bupivacaine	Not stated	Not Stated	Other
Patient was admitted in [month/year] with a major bilateral pulmonary emboli. As patient was also found to have iron deficiency anaemia patient was discharged on low molecular weight heparin (clexane) until investigations of the anaemia had been completed - specifically a colonoscopy. The patient was supplied with 30 days of clexane on discharge and the medical team and pharmacist expected that primary care would continue the clexane prescriptions. The GP practice however refused to this as the clexane was only planned to be a temporary treatment i.e , until the colonoscopy had been undertaken and sinister pathology excluded and so was not covered by a shared care agreement between the hospital and primary care. The practice pharmacist contacted the hospital pharmacy and a further 30 days treatment was subsequently arranged via Pharmacy	enoxaparin	none	Not stated	none	Omitted medicine / ingredient

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
and [Dr]. The patient was advised by Pharmacy to contact [Dr] secretary , and , or Pharmacy if ran out again. The patient then decided not to have the colonoscopy and this decision was communicated to [Dr] who wrote to the GP suggesting that the patient be started on warfarin but also advised that the clexane should be continued until the INR was therapeutic. The patient was referred to the anticoagulant clinic and was started on warfarin at a low dose. In the meantime the patient had run out of the clexane. Patient contacted the surgery on the [date] about this and was again told to contact the hospital , but there is no evidence that the patient did so. In consequence the patient was no longer anticoagulated. The anticoagulant nurse discovered the patient was not on clexane when the low dose warfarin was commenced but did not understand the significance. The patient was subsequently admitted as an emergency on the [date] after a collapse. The Patient was clerked in by an [Staff] who thought that the patient had probably experienced a vaso - vagal collapse. The INR returned at 1.0 indicating the patient was not anticoagulated so the F1 doctor prescribed a higher dose of warfarin but not any clexane. Due to a very high volume of					

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
admissions the patient was not seen the day of admission by a consultant and subsequently had a cardiac arrest and died the following morning. Due to the lack of senior review and uncertain cause of death the case was reported to the coroner and an inquest is to be held in [month/year]. The lack of senior review on admission has already been investigated and since that time a cloud rota with second consultant assisting with review of patients on the AMU at weekends has been introduced. At post mortem the patient was found to have bilateral pulmonary emboli which had been present for at least several days. The cause of death was therefore not an acute pulmonary embolus though the pulmonary emboli may well have directly or indirectly caused the death , perhaps by causing a dysrythmia. The problem here is the failure of continuation of clexane until anticoagulation from warfarin was adequate. The hospital had advised the patient would need to call for further supplies and the GP advised the same but the patient did not do so. The hospital does not have a repeat prescription system for chasing up lapsed prescriptions that would alert staff that this was a problem.					
There was a failure to prescribe enoxaparin as VTE prophylaxis on admission despite	enoxaparin	none	Not stated	none	Omitted medicine /

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
the risk assessment being completed. The patient did not receive enoxaparin for the first 2 days. It was prescribed and given on the 3rd day. The patient died on the 4th day , possibly from pulmonary embolism. (Post mortem report awaited.). Secondly , the patient oxygen saturations dropped to 88% on air about 20 hours before the patient had a cardiac arrest. Oxygen was administered but no further action was taken and the nurse does not appear to have informed a doctor about this.					ingredient
Patient admitted [date/time] following fall and head injury. Had CT head at [time] on day of admission. CT showed no bleed. ECG showed ST elevation and patient was treated for ACS with clexane , aspirin and clopidogrel. Clexane dose based on weight estimate - 100mg given as stat (at approx [time] - notes unavailable at time datix written). The clexane was prescribed regularly on chart as 100mg BD. Patient not weighed until morning ward round on [ward] - weight 50kg. Clexane represcribed as 50mg BD at [time] and [time]. Patient given second dose of clexane (50mg) at [time]. Patient found unresponsive in chair later in morning. Urgent CT head at [time] showed subdural haemorrhage with midline shift and coning. Patient passed away later that day..	enoxaparin	enoxaparin , aspirin and clopidogrel	50mg BD	Enoxaparin dose based on weight estimate - 100mg given as stat then prescribed regularly on chart as 100mg BD; aspirin and clopidogrel not stated.	Wrong / unclear dose or strength

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
Anticoagulation chart reviewed on ward round [date]. Noticed Warfarin was withheld on [date] due to poor swallow ability. Also crossed off for [dates]. INR - insufficient sample on admission and not rechecked. Warfarin was then prescribed on [date] and [date] at 1mg each. Doctor has documented reason for this in the notes. Vit K prescribed on [date] when INR came back at 11.1. Vit K not given until [date] and patient later arrested that day. Post mortem subsequently showed cause of death as SDH (coroners referral).	vitamin K	none	Not stated	none	Other
The issue identified at a pre inquest meeting is in relation to the deceased patient treatment following second transplant on [date]. An immuno - suppressed post - transplant renal patient should be prescribed septrin for 6 months to provide cover against the risk of bacterial infection. This is recommended in the NICE guidelines. There was no evidence that the deceased was prescribed septrin post - operatively or on discharge on [date]. The evidence provided by [Hospital] (where the deceased was admitted on [date] and where the patient subsequently died) confirms that , on admission , the patient had probable pneumocystis pneumonia (PCP) which microbiology results confirmed days later. Crucially, this is the type of	co-trimoxazole	none	six month's prophylactic cover	none	Omitted medicine / ingredient

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
bacterial infection which the administration of septrin is designed to cover. The [Hospital] commenced the deceased on septrin from the [date] onwards. Post operative instructions were clearly documented , seemingly not followed , and at no point was the omission rectified.					
Patient transferred from [ward]. Initially admitted with chest pain and treated as possible ACS with clexane theraputic dose , received 3 doses during admission. patient recently discharged from vascular unit and restarted on warfarin. INR on [date] was 2.1 5 - on consultant ward round on [date] found not responsive with right sided weakness. CT brain showed large left sided intracranial bleeding. INR on [date] was 3.0 8 - Haematology Dr contacted and advice taken to reverse the anticoagulation and treatment given. Neurosurgeon contacted for advice.	none	warfarin	none	Not Stated	Wrong / unclear dose or strength
Patient admitted from [place] [time] of the [date] with epistaxis to [ward/Hospital]. On warfarin for atrial fibrillation , recent slight increase in dose according to admitting doctor. INR greater than 10. No reversal of warfarin given on admission or during the subsequent day. Nose packed and ENT doctors satisfied that bleeding appeared controlled. approx [time/date] [Staff] noted that seemed less responsive with GCS 12 /	beriplex , vitamin K and tranexamic acid	none	Not stated	none	Other

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
15 - arranged CT brain and referred for medical review via medical consultant on call. [time] arrest call put out for peri - arrest situation. Patient was having a large episode of epistaxis and became haemodynamically unstable with risk to airway due to bleeding. Management initiated with urgent arrangement for Beriplex to reverse INR , Vitamin K and tranexamic acid also given. Fluid and blood resuscitation and major haemorrage pathway activated via switch. Anaesthetic SpRs and subsequently anesthetic consultant involved to secure airway by intubation and ventilation. Brief cardiorespiratory arrest with return of spontanous circulation after 2 cycles approx [time]. Bleeding settled after beriplex and repeat INR 1.4. Became haemodynamically stable on ventilator. Transferred to CT scan for CT Brain due to concerns about low GCS prior to above events. CT showed large intracerbral bleed. Discussed with neurosurgical [Staff] at [Hospital] - no surgical options , advised conservative and comfort management. Due to CT findings decision made to extubate and keep comfortable. Family updated throughout. Died 10 minutes after extubation , [time/date]. Incident reported due to non - reversal of warfarin in the context of active					

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
bleeding.					
The patient was diagnosed with bilateral pulmonary emboli with evidence of Right Heart strain on the [date]. Patient was administered a dose of Fragmin at [time] on [date]. Patient was subsequently prescribed Rivaroxaban on the [date] to commence on the following day. This was not administered ; the reason being that the drug was not available. The patient was also not prescribed an alternative anticoagulant. The patient was transferred to [Ward] on the [date]. On the following day the patient became more unwell , had a cardiac Arrest and passed away despite prologed CPR.	rivaroxaban	none	Not stated	none	Omitted medicine / ingredient
Admitted [date]. BIBA as sepsis call appropriate treatment in A&E and referred to medical team. Junior Doctors initial impression was more Infective Exacerbation of Chronic Obstructive Pulmonary Disease. Written up for 5,000 units Dalteparin to be given at [time]. Venous Thrombo Embolism risk assessment completed. Admitted to [Unit] at [time]. Post take ward round at [time] possible Pulmonary Embolism or fibrosis part of plan was for CTPA & therapeutic Dalteparin. Continued on prophylactic dose rather than treatment dose. Transferred to	dalteparin	dalteparin	15000 units treatment dose	5000 units	Wrong / unclear dose or strength

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
[Ward] at [time]. CTPA requested on [date] , chased and finally done at [time] on [date]. Meanwhile only had 5,000 units Dalteparin for 2 days. CTPA multiple , extensive Pulmonary Embolism with evidence of right ventricular strain. Commenced on 15,000 units Dalteparin (wt = [kg]). For thrombolysis if unwell / compromised. [date] dropped Blood Pressure , moved to CCU and thrombolysed [time/date] Peri - arrest call [time] , bleeding post thrombolysis , liver & kidney failure. Died [time] , verified [time].					
Patient admitted for elective gynae surgery beginning [month]. Had a long admission which involved 6 bed moves whilst in - patient stay. Was prescribed chemical TP (clexane). x1 dose omitted on [date] - no reason documented. Was discharged with extended TP into rehab setting. Cannot complete RCA as unable to locate 3rd drug chart.	enoxaparin	none	Not stated	none	Omitted medicine / ingredient
Patient was admitted to [Ward] on [date] with severe back pain - discharged on [date]. RA completed but only steps 1&4 - no clotting / bleeding risk assessed. No mechanical TP used. Given appropriate chemical TP however 2 doses omitted on last 2 days of stay - no reason for omission. Physios commented on SOBOE but not commented on by doctors. Patient unwilling	enoxaparin	none	propylactic dose (un-specified)	none	Omitted medicine / ingredient

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
/ unable to mobilise due to pain. Patient died [no.] days post discharge and PE was found as cause of death during community post - mortem.					
It was discovered during the patients coroners inquest that patient had received 7 cycles of chemotherapy instead of 6 cycles as prescribed at the start of treatment.	Chemotherapy (un-specified)	Chemotherapy (un-specified)	6 cycles	7 cycles	Other
Visited patient with qualified member of staff. Call from patient's spouse that patient in pain and nausea. Palliative patient. On syinge driver. CSN drew up whole ampoule of morphine sulphate 10mg in 1ml and 0.25ml (6.25mg) of levomepromazine. Drawn up in 1ml syringe , CSN stated ' its over 1 ml but it will be ok. ' Therefore , whole ampoule of morphine must have been drawn up when patient authorised for 2.5mg. Patient spouse rang Hub half an hour later to say patient had died and asking if the injection had killed the patient. Medication was drawn up to be administered sub - cutaneous as a stat dose for symptom management. Full investigation to be done following disciplinary procedure as per Medication Error SOP. Nurse involved having period of supervision until competencies observed and signed off as per Medication Error SOP.	Morphine sulphate & levomepromazine	Morphine sulphate & levomepromazine	2.5mg & 6.25mg	10mg & 6.25mg	Other

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
Problem identified during consultants ward round that staff nurse had not given morning medications due to patient being too sleepy and difficult to rouse , but shortly afterwards 15mg methadone liquid had been given. On further investigation it was discovered that the methadone had been given to the wrong patient. Medical team informed. Full set of observations performed. Initially 1 hourly observations performed but respiration reduced and 15 minute observations continued. Medication error explained to patient. Unfortunately no family present at the time. 2 X 100mg naloxone given s / c and after 2nd dose was responding to family and staff. Further investigation showed that staff had not checked treatment sheet with identification bracelet and that the two nurse had taken two different controlled drugs to different patients and had taken them separately and individually. Family informed of the drug error when they arrived on the and apologies given.	none	Methadone, Naloxone	none	15mg, 2x100mg	Mismatching between patient and medicine
*Investigation Report date given as Date Incident Completed. Delay in giving Gentamicin antibiotic to a septic patient. A patient with a [cancer] was receiving Outpatient chemotherapy " OxMdG " at[Hospital 1] and had a Hickman line in place. The patient's spouse called their GP	Gentamicin Amoxicillin Metronidazole	Tazocin Gentamicin	Not stated	Not stated	Omitted medicine / ingredient

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
on [date/time] , who visited the patient at their home and arranged emergency transfer to hospital , describing the patient as being unwell with vomiting over the last 2 days and finding the patient febrile on examination. Normally , a patient on chemotherapy would telephone the department looking after them. The patient was taken to the nearest A&E Department in view of the severity of the emergency , rather than to [Hospital 1]. The patient was admitted to the A&E Department at [Hospital 2] at [time] and found to have an EWS of 7. Patient was resuscitated with fluids and received a dose of Tazocin 4.5g IV at [time]. The neutropenic sepsis protocol is available on the Intranet and is on the emergency medicine site , however , a search for the protocol does reveal other information that could be read instead. It suggests Tazocin and Gentamicin as first line drugs upon confirmation of neutropenia , preferably within 20 minutes of suspecting neutropenic sepsis. It also does state that a single dose of Meropenem may be given if the patient is " severely unwell " , before blood tests are known. In this case , Tazocin was given relatively quickly in the A&E Department , but the Gentamicin was prescribed for [time] on the regular section of the prescription. One explanation for this					

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
would be that the renal function should be known prior to prescribing Gentamicin , as advised in the protocol. The patient blood tests became available at [time] and the patient was found to be not neutropenic and was therefore switched from the neutropenic regimen to the Trust non - neutropenic sepsis regimen AMG (Amoxicillin , Gentamicin and Metronidazole). The Gentamicin was therefore prescribed after the blood tests were made available and it was written up alongside the Amoxicillin and the Metronidazole. The Gentamicin was prescribed to be given at [time], however , this was not given. This was the time at which the patient was moved from the A&E Department to the Acute Admissions Unit. That evening , the patient deteriorated and the nursing staff alerted the On - call Doctor , who noticed the omission. Gentamicin was then prescribed and given. The patient died the following day at [time].					
Patient was admitted to hospital for laparotomy and cystectomy. Patient was given paracetamol 1 gram paracetamol IV QDS. Patient presented to ITU with worsening liver function , ALT&gt2000 , PT90. Worsening confusion. Paracetamol level of 90.	Not stated	paracetamol	Not stated	1 gram four times a day intravenously	Wrong quantity

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
Patient had type 1 diabetes. Patient had been on insulin for 40 years. No insulin given since the day before. Patient had high blood glucose and had blood ketones. Bicarbonate 8. Resulted in diabetic ketoacidosis.	insulin	none	Not stated	none	Other
Routine review of deceased patients notes following a cardiac arrest call by [Staff]. On review of medical notes this patient had multiple - co - morbidites and had a VTE risk assessment performed indicated he was at high risk of VTE. He was admitted to [Place] on [Date]. He was commenced on Dalteparin 5000iu OD which he received on the [date] [date, time]. A pharmacist wrote both on his drug chart & in the medical notes (not certain of time but between two entries times at [time 1] [time 2] that this patient should be on 7500iu BD due to his weight (180KGS) Patient found in cardiac arrest on the bathroom floor at [time] am on the [Date]. Resuscitation unsuccessful. Incident : was this patient prescribed the correct dose of Dalteparin in view of his co - morbidities & weight ? Would this have altered the outcome ?	dalteparin	dalteparin	7500 iu twice daily	5000iu	Wrong / unclear dose or strength
ERCP case - patient found drowsy during the following night , some improvement with flumazenil so possibly related to sedation. Patient never recovered and died 3 days later.	Not stated	midazolam followed by flumazenil	Not stated	Not Stated	Adverse drug reaction (when used as intended)

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
The patient was brought to A&E on [date] after a fall with swelling to nose and face. A CT head scan was undertaken and there were episodes of epistaxis. Patient suffered a peri arrest and cardiac arrest and was admitted to ICU , the major haemorrhagic pathway was activated but despite CPR the patient could not be resuscitated and died.	vitamin K	none	Not stated	none	Omitted medicine / ingredient
Trimethoprim given to patient with Rheumatoid Arthritis on Methotrexate.	Not stated	methotrexate and trimethoprim	Not stated	Not Stated	Contra-indication to the use of the medicine in relation to drugs or conditions
A patient was admitted to ITU from CSRU on [date] at [time]. The patient looked extremely unwell on arrival to ITU requiring non - invasive ventilation for respiratory support. GCS 6 out of 15 (Eyes 3 , motor 1 , verbal 2) , pupils size 6mm and not reacting to light. Heart rate was 40 beats per minute requiring a continuous isoprenaline infusion running at 30ml / hr (preparation of drug was 10mg in 50 ml of normal saline). Blood pressure 100 / 41mmhg. Isosorbid dinitrate 1 mg / hr was also being infused. During the handover to ITU I questioned the [Staff] and [Staff] from	Not stated	isoprenaline infusion ; isosorbide dinitrate; adrenaline	Not stated	isoprenaline infusion running at 30ml / hr (preparation of drug was 10mg in 50 ml of normal saline); isosorbid dinitrate 1 mg / hr; adrenaline 5mgs in divided doses	Wrong / unclear dose or strength

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
[Place] regarding the dose of isoprenaline as I was unfamiliar with the protocol for administration. I was told the plan was to continue the isoprenaline at the same dose and rate of infusion until pacing was performed , planned for the next morning. At [time/date] , the patient vomited approximately 50mls and became extremely bradycardic 10 beats per minute. Atropine was given by the ITU [Staff] , a crash call was activated and CPR commenced. The family was contacted and informed of the patients deterioration. The resuscitation team arrived. The patient received 8 cycles of CPR and 5mgs of adrenaline in divided doses as per resuscitation protocol. The resuscitation was unsuccessful and the patient was pronounced dead at [time].					
When administering rectal diazepam to a paediatric patient it was impossible to determine how much of the 5mg rectal tube to waste in order to provide the required , correct , dose for the patient. It is understood we do NOT have the 2.5mg doses in circulation and are therefore required to waste the surplus amount prior to rectal administration. This is however impossible to gauge due to the tubes not being transparent and due to the technique suggested being based on a guess. On this	diazepam	diazepam	2.5mg	5mg	Wrong / unclear dose or strength

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
occasion the required dose was 2.5mg so I attempted to waste half of the total volume prior to administering the remaining 2.5mg. Shortly after administration the patient suffered severe respiratory depression and required ventilatory support en - route to hospital.					
This gentleman with idiopathic pulmonary hypertension is delivered Treprostinil from Healthcare at Home and this is administered as a continuous subcutaneous infusion. The wrong strength of drug (5mg / ml)had been delivered and the patient had not realised until felt more unwell and became increasingly more breathless over a 2 day period. As patient was too unwell to change own infusion the patient's daughter changed it and noticed that the strength was wrong. She used another bottle of the correct strength of drug (10mg / ml) and changed the patient's infusion. Patient then developed severe side effects from the increased dose of Treprostinil and became hypotensive , nauseated and less responsive.	Treprostinil	Treprostinil	10mg / ml	5mg / ml	Wrong / unclear dose or strength
Patient with GIB following recent initiation of a NOAC.	Not stated	apixaban	Not stated	Not Stated	Other
nurse from out of hours was called out to attend to end of life patient for symptom control. patient under care of hospice with night sitter present. patient agitated and	alfentanil	alfentanil	0.1mg to 0.2 mg	1mg	Wrong quantity

Incident description	Should have received (name)	Did receive (name)	Should have received (Quantity or Dose)	Did receive (Quantity or Dose)	Medication error type
requiring further medication. nurse recognised patient to be end of life and actively dying. drugs were in the house for stat doses , as well as patient having syringe driver in progress. nurse read medication chart , and identified drug within dispensing box. Drug range reported to be different to that on the chart. chart states dose to be 0.1mg to 0.2 mg and box range states 0.5 mg - 1.5mg. nurse administered 1mg. settled patient and left property. patient passed away shortly after visit. carer noted error whilst writing notes and escalated to hospice. police called and family informed of error.					
Shared [Date] Meeting held with [Staff] and [Staff] and [Place]. [Ambulance] brought Patient to A&E who was then admitted [Time]. As a general medicine patient with Haematology on previous admission . Patient had a cardiac arrest @ [time] same day . PM report noted overdose of oxycodene as a cause of death (RM) . .	Not stated	oxycodone	Not stated	Not stated	Wrong / unclear dose or strenth