NHS Resolution

Did you know?

Insights into medication errors

Advise / Resolve / Learn

Did you know?

From 1 April 2015 until 31 March 2020 NHS Resolution received 1420 claims relating to medication errors. Of those claims:

- **487** claims were settled with damages paid
- **438** claims were without merit
- **495** remain open

Total cost of closed claims = £19,324,495
Total damages paid in closed claims = £10,419,356

The analysis held within this leaflet only focuses on closed claims that have been settled with damages paid and concern an element of the medication process: prescribing, transcribing, dispensing, administering and monitoring.

Medication errors are any Patient Safety Incidents (PSI) where there has been an error in the process of prescribing, preparing, dispensing, administering and monitoring or providing advice on medicines.

The NHS Patient Safety Strategy has a strategic focus on medication errors, with the Medicines Safety Improvement Programme addressing the most important causes of severe harm associated with medicines. The programme aims to reduce severe avoidable medication-related harm by 50% by March 2024.

Key ambitions at time of publication are:

- to improve the safe use of anticoagulants.
- to reduce harm from opioid medicines used for chronic pain.
- to reduce avoidable readmissions by increasing uptake of the Discharge Medicines Service.

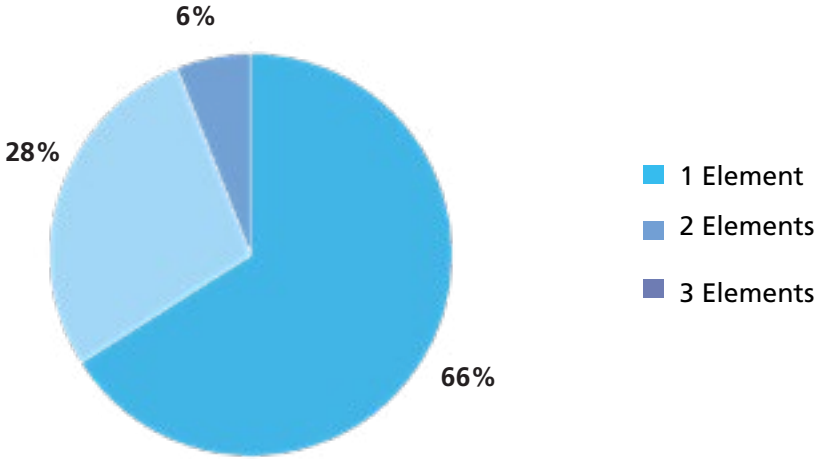
Key facts

Did you know? Medication errors can occur at many steps in patient care, from ordering the medication, to the time when the patient is administered the drug. In general, medication errors usually occur at one of these points:

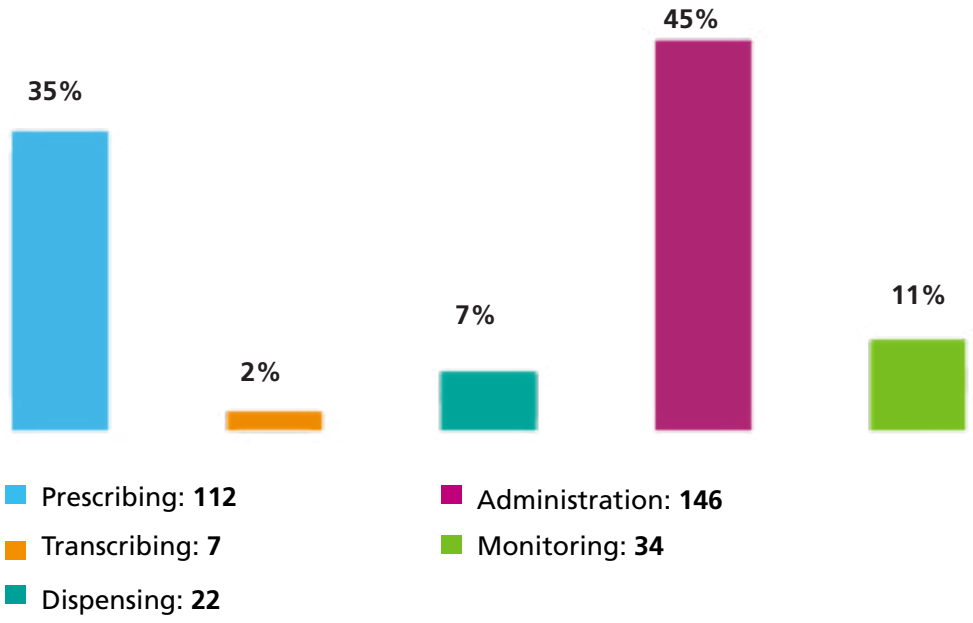
- prescribing
- transcribing
- dispensing
- administering
- monitoring

1 NHS England » The National Patient Safety Strategy

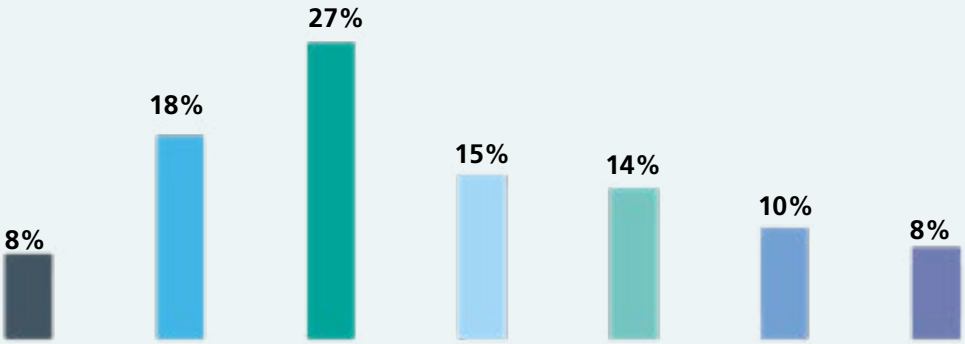
Did you know? 66% of medication error claims only concerned one element of the medication error process.



Did you know? Of the 321 claims that concerned one element of the prescribing process, an error in administration occurred most frequently.



Did you know? The administration errors identified in these 146 claims were analysed further. The following errors were identified



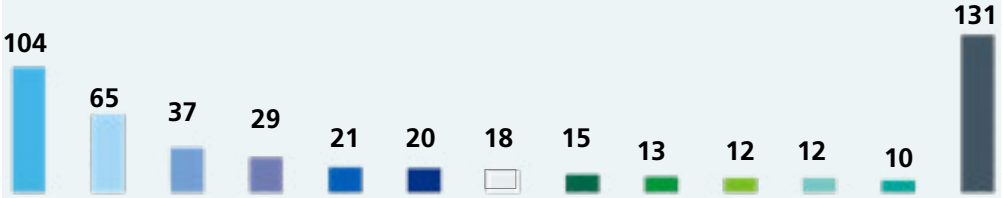
- Wrong patient: **13**
- Wrong dose: **45**
- Delay/omission: **23**
- Wrong drug: **31**
- Wrong route: **25**
- Contraindicated: 17
- Poor technical skills: **14**

*Poor technical skill - eg Injection/Infusion technique

Of these 146 claims, 17 (12%) concerned more than one of the above administration errors. 168 different administartion errors were observed in the 146 claims reviewed.

Did you know? From the NHS Resolution initial data for medication errors, the most common medications to be implicated in claims are:

- anticoagulants
- antimicrobials
- anti-convulsants
- opioids
- antidepressants



- Anticoagulants: **104**
- Anti-convulsants: **21**
- Immunosupressants: **13**
- Antimicrobials: **65**
- Anti-depressants: **20**
- Adrenaline: **12**
- Opiates : **37**
- Local anaesthetic: **18**
- Steroids : **12**
- General anaesthetics: **29**
- Insulin: **15**
- Chemotherapy : **10**
- Other: **131**

Examples of claims received highlighting that the cost is not just financial:

- Fatality due to bleed following organ biopsy as heparin mistakenly administered after biopsy
- Failure to calculate and administer the correct dosage of morphine resulting in ongoing impairment of function
- Fatality due to failure to administer anticoagulant in a timely manner, subsequently leading to death as a result of pulmonary embolism
- Inadequate anaesthesia for caesarean section leading to pain and Post Traumatic Stress Disorder

What actions can you take?

- Ensure a designated person monitors the Medicines and Healthcare products Regulatory Agency (MHRA) medication safety updates and cascades and actions accordingly
- Organisations should report all medication incidents, take action to improve medication safety locally and work with local safety champions
- Ensure robust policies and procedures exist for medications
- Cascade local medication administration policies, regulations and guidelines
- Implement medication reviews and have local safety champions
- Ensure prescribing audits are routinely carried out
- Regular review of own organisations medication errors claims
- Ongoing education to ensure frontline staff are aware of medication errors
- Consider collaborating with the Medications Safety Improvement Programme at future.nhs.uk/MedicinesSafetyImprovement

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www.resolution.nhs.uk