Overview of Medication Incidents Reported to the Clinical Indemnity Scheme

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Overview of presentation

- Overview of Medication Events notified to the State Claims Agency between 01/01/2004- 31/12/2010
- Overview of Medication Events notified by Mental Health Services.
- Analysis of data and emerging issues

Medication events reported by specialty

Specialty	percent
Medicine	53.8
Surgery	17.5
Paediatrics	6.1
Disability	3.3
Emergency Medicine	3.2
Other	3.2
Mental Health	3.0
Obstetrics	2.7
Anaesthesia	1.5
Haematology	1.1
Allied Professional Services	1.1
Elderly Services	1.1
Gynaecology	0.9
Community Health Services	0.7
Radiotherapy	0.4
Radiology	0.3
Laboratory Services	0.1
	0.0

Clinical Indemnity Scheme

Top 10 medication events reported

State Claims Agency

Medication event	Value
Incorrect dosage	19.7
Missed Medication	14.2
Other	14.1
Incorrect medication	11.7
Incorrect directions / labelling	5.1
Medication on admission/discharge/transfer incorrect or not reconciled	5
Incorrect Rate	3.2
Incorrect time	2.8
Incorrect Patient	2.8
Incorrect frequency	2.2

Axis: 0, 5, 10, 15, 20, 25

Tús Áite do Shábháilteacht Othar
Patient Safety First

Clinical Indemnity Scheme

Top 10 medication events Mental Health services

Gníomhaireacht Éileamh an Stáit
State Claims Agency

Event	Value
Incorrect medication	20.9
Inappropriate self-medication	14.8
Incorrect dosage	13.5
Other	11.6
Missed Medication	9.9
Incorrect Patient	6.4
Incorrect time	3.8
Unsatisfactory Drug Security	3.2
Incorrect directions / labelling	2.6

0.0 5.0 10.0 15.0 20.0

Tús Áite do Shábháilteacht Othar
Patient Safety First

Who reports medication events?

Gníomhaireacht Éileamh an Stáit
State Claims Agency

Staff group	Value
Nursing / Midwifery	45.34
Not stated	26.76
Allied Healtlh Professional	19.28
Medical	4.31
Other	3.22
Care Staff/Social Care Staff	0.80
Administration Staff	0.27
Ambulance Staff	0.01
Security	0.01
Instructor/Teacher	0.00

Axis: 0.00, 5.00, 10.00, 15.00, 20.00, 25.00, 30.00, 35.00, 40.00, 45.00, 50.00

Tús Áite do Shábháilteacht Othar
Patient Safety First

Incident reported by:

Time of occurrence of medication event

Patient on Methotrexate 7.5mg weekly; Methotrexate 2.5mg three times daily charted – patient received 5 doses

160 units of Novarapid ... given in error. Misread correct dose of ...

- Patient was loaded with warfarin on 10, 10 5 schedule. No INR was done until 4th day. INR was greater than 10 on this day and vitamin K was given. This lead to a prolonged period to get a target range INR (10 DAYS) and was dangerous for the patient.

Examples of medication incidents reported by mental health services

Medication Management

Monitor and Evaluate

- Prescribe
- Dispense
- Supply
- Administer

The Five Rights of Medication Administration

- **Right** Drug
- **Right** Patient
- **Right** Dose
- **Right** Route
- **Right** Time

Right Drug

- patient was given Fluoxetine 'Norzac' 100mg instead of Fluvoxamine 100mg.

- NB Same patient, same ward 1 month later

  patient was given Fluoxetine 'Norzac' 100mg instead of Fluvoxamine 100mg.

Right Patient

- Patient took a cumulative dose of 575mg of clozapine that was not intended for him. The medication was delivered to his home by taxi but the delivery was intended for another patient who attends hospital for clozapine treatment.

- Mistaken identity of patient - incorrect meds administered.
- Pt was mistakenly given medication prescribed for another client ie. Zanax 0.25mg, stilnoct 10mg, olanzepine 2.5mg. Error was immediately identified and appropriate procedure implemented.

Right Dose

- client was transferred from tablet to liquid form Lithium 2 months previous, dose miscalculated in the transfer and ended up receiving 1/4 dose in the 2 month period until error discovered
- Pt mistakenly given more than the dose of ECT she was meant to have. The pointer was at 400mC, but unknown to staff, the button was at high voltage. Pt eventually had 1,200mC.
- Patient was given prozac 180 mg daily instead of a weekly dose tablet.
- 8mg of warfarin administered to patient . INR rose to 4.5 on 8/11/04. A further 8mg withheld on 8/11/04. Dr ****** who had prescribed warfarin informed. She confirmed that although it appeared to be a dose of 8mg it was actually 5mg but written unclearly.
- Asked to give out medication to some service users in unit. Checked prescription chart for Pt A. Meds. due at 8.30 pm. Read prescription and administered meds. Proceeded to sign recording sheet. Same already signed. Meds. given already.

Right Route

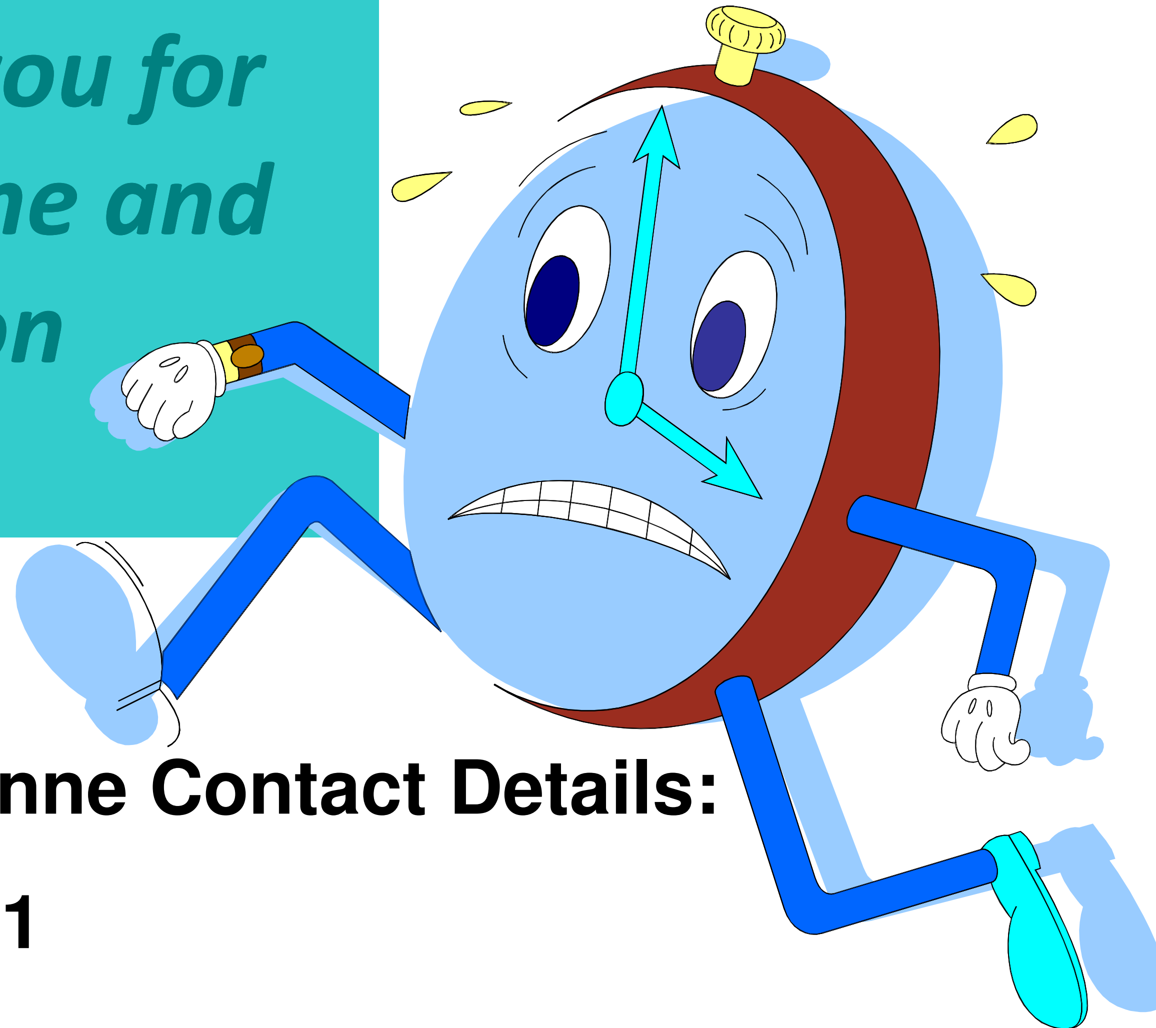
- Pt was given medication to take in her inhaler but took it orally. Dr attended. Medical officer & poison centre contacted. Vital signs monitored half hourly for four hours as advised. No adverse reactions noted.
- At 14:30 hrs I gave pt his insulin. He used his jaw as the injection site. I advised pt of the inappropriate site used.
- At 10:30 hrs, the patient swallowed his Spiriva capsule 18 mg which was for his inhaler.

Right Time

- patient did not receive his prescription of insulin. no adverse effects. prescription had been changed from night time to day time and staff nurse overlooked this resulting in omission.
- Patient given Augmentin Duo 625mgs tds instead of bd script written clearly

- Is the current data representative of medication safety within mental health services?
  - How do we know?
  - You cannot manage what you don't measure BUT also
    - "the most important figures that one needs for management are unknown or unknowable (Lloyd S. Nelson, director of statistical methods for the Nashua corporation), but successful management must nevertheless take account of them."

Thank you for your time and attention



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