

Category: Medication

Preventing: Harm from unintended doses

Key words: Wrong patient, unintended doses, administration error, patient identification, controlled drugs

Sharing Learning Points

LOCALLY



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What happened?

A patient was given another patient's medicines, including controlled drugs, in error resulting in harm.

Neither the Procedure for the [Administration of Medicines by Registered Healthcare Professionals Working Within NHS Grampian](#) nor the [Policy and Procedure for the Safe management of Controlled Drugs in Hospitals and Clinics by Clinical Staff Working Within NHS Grampian](#) were followed resulting in two nurses signing CDs out of the CD cupboard/book but only one nurse completing the process at the bedside. The computer on wheels with HEPMA was not brought to the bedside and a patient identity check was not completed.

The patient received multiple tablets not intended for them. The patient's condition deteriorated as a direct result and they required treatment with Naloxone.

In the past year within the acute sector, 1-3 wrong patient administrations are reported in Datix each month.

What went well?

- The immediate response following the error
- Duty of candour with the patient and their family.

What, if anything, could we improve?

- Adherence to administration procedures and CD policy.
- Completing bedside patient identification checks
- Taking the computer on wheels with HEPMA to the bedside.

What have we learnt?

- Not following policies and procedures can lead to errors.
- Patients can experience harm as a result of errors.
- Bedside identity checks are an important part of the of the administration process and must be completed.
- Identification checks must be completed against the HEPMA record.

If you have any comments about this or any similar adverse event please send them to:

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