Reporting of Medication Incidents in Surrey ICPs Quarter 4 2021-22
Example of Incidents and Learning Points

Medication safety incident reports from GP practices in Guildford & Waverley, North West Surrey, East Surrey and Surrey Downs were collated for the quarter 4 report (Jan-March 2022). **Some common themes and learning points are described below – please share as widely as possible and discuss with your colleagues**

Liquid Medicines

- We continue to see errors involving liquid medicines with doses calculated incorrectly, prescribed incorrectly and dispensed incorrectly.
- A recent HCIB report detailed an investigation into an unintentional overdose of morphine sulphate liquid resulting in death

Learning Points

- Ask for an INDEPENDENT calculation of dose to be prescribed
- Clearly document dose on prescription so this is transferred on to the dispensing label
- Take extra care when prescribing and labelling liquid medicines- particularly for children
- Counsel the patient around the volume of liquid medicine they should take and explain how this can be measured

Unusual Doses

- Hospitals may sometimes prescribe unusual doses of medication. For example, a higher than normal dose of enoxaparin was prescribed to a patient weighing over 100kg. This was not clearly communicated to the practice who thought there had been an error and inadvertently reduced the dose.

Learning Points

- Acute Trusts should clearly communicate to primary care where a dose has been adjusted, giving the reasons
- Unusual doses should be checked with the prescriber to clarify their intention if this is not documented on the request

LASA Errors

Look alike sound alike errors reported this quarter are

- Oxycodone prescribed instead of oxybutynin
- Co-amilofruse prescribed instead of co-amilozide

Learning Points

- When selecting drugs from a picklist, always type in as many letters as possible before making your selection to avoid inadvertently choosing a similar sounding drug
- Report all LASA errors – even if a near-miss as this will allow clinical systems to be updated

Electronic Repeat Dispensing

- A patient on eRD was able to obtain their benzodiazepine prescription early, leading to potential for overuse

Learning Points

- Benzodiazepines are generally not suitable for eRD and practices should consider other methods, e.g. weekly or 2 weekly prescriptions to prevent overuse

Reporting Incidents

- Please report any patient safety incidents using your local system.
- For GP practices this is LFPSE which can be accessed here
- Please continue to send a pdf copy of the incident report to carol.cunningham9@nhs.net

Learning Points

- Surrey Heartlands Medicines Safety programme promotes a "just culture" which supports staff to be open about mistakes allowing valuable lessons to be learnt so the same errors can be prevented from being repeated.
- By reporting incidents you are helping to share learning

Many errors were prevented from causing any harm when they were spotted by another healthcare professional

Remain Vigilant and Report Near Misses As Well As Errors Reaching The Patient