Medication incidents reported 01/01/2024 to 31/12/2024
Listing report with actions taken and lessons learned

Ref	Date incident reported	Date of incident	Time of incident	L6 Service	L9 Team	Organisation responsible	Category	Sub category	Overall severity	Type of medication incident	Stage at which medication incident occurred	Drug administered	Was drug actually administered?	Dose administered	Correct dose	Route administered	Correct route	Description of incident	Action taken at time of incident	Action taken as a result of review	Lessons learned	Approval status
GHC63559	01/01/2024	01/01/2024	12:55	Assertive Outreach	AOT West	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Ordering, collection or delivery	Olanzapine	No					Patient called, via the Contact Centre, to report he had not received a delivery of his medication (4 days worth). The contact centre reported the patient had called up in an anxious state. If the call had come in 5 minutes later AOT staff would not have taken the call as operational hours have finished. Delivery of medication was included in todays's job as an action and therefore not known about. Job subsequently found in 2023 diary although on today's date.	Medication delivered	medication delivered to patients next day	Staff reminded of the use of the daily diary in AOT	Closed
										Supply issue	Ordering, collection or delivery	Diazepam	No									
										Supply issue	Ordering, collection or delivery	Zopiclone	No									
GHC63563	01/01/2024	27/12/2023	14:30	ICT	ICT Glos HQR DN	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Pharmacy	Bisoprolol	No					Patient discharged from CGH Acute Care Unit HASU on 24th December 2023 with medication belonging to another patient. BISOPROLOL 7.5MG Dispesary label prescribed to a GILLIAN MARY MATHEWS MRN0326591	Checked patient's discharge medications. Patient has BISOPROLOL but at a lower dose 1.25mg.	Identified raised with GRH. No harm caused Medication returned to pharmacy	None	Closed
GHC63615	02/01/2024	02/01/2024	20:00	Cirencester & Fairfrd Hospital	Ciren Hosp-Windrush Ward	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Pharmacy	Insulin glargine	Yes	7 units	18 units	Subcutaneous	Subcutaneous	Semglee (Insulin glargine) 18 units prescribed to give to patient at 20:00. However there was only 8 units left in the vial and no other Semglee insulin available in the hospital. (Patient admitted to ward 2 days prior to this incident)	Nurse responsible for patients care at this time measured his blood sugar and it was 7.1 - they omitted the insulin at this time and wanted to seek advice form the OOH service about the action to take. Situation handed over to night staff. Night staff contacted OOH and advice given was to given the partial dose of Semglee as his blood sugar was stable. To monitor his blood sugar during the night and in the morning. To contact OOH service if BM greater than 20. Otherwise ward doctor to change prescription to Lantus (as known shortage of Semglee at this time). Apology given to patient for the situation.	Having reviewed this incident, the patient was transferred to this Trust with insufficient supply of prescribed Insulin. A suitable alternative was prescribed and sourced, and the patient was monitored appropriately.	The nursing staff could have noticed earlier that there was insufficient supply before this was discovered at the point of administration.	Closed
GHC63633	03/01/2024	27/12/2023	16:35	ICT	ICT Stroud Cotswolds DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Fentanyl	Yes	100mcg	100mcg	Topical	Topical	Discrepancy regarding total of trans-dermal patches present. Documentation stated 26 patches, but 22 patches present.	Reported to shift lead.	2/1/24- all duty noted feedback passed on to team. New tin provided with new code and drug chart to be changed to a green drug chart to replace MAR chart so that stock balance is only recorded on one record. Reminders sent to staff to ensure any visitors to property do not see the digits on the security entered, left visible, while treating the patient and is securely closed after use out of sight of any visitors. All staff thanked for their vigilance and action on this matter.	As above.	Closed
GHC63674	04/01/2024	02/01/2024	11:00	Long Term Conditions	Bone Health Service	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Contra-indication in relation to drugs or conditions	Prescribing	Alendronic acid	No					I reviewed the patient in Gloucester Hospital on 2nd Jan 24. I documented in their electronic records that I had discussed Alendronic Acid for bone strength with patient however ended by saying I would review the bloods (calcium level) which I requested at the time of the consultation for the next day) and would then prescribe appropriately. The day after the blood had been collected 4th Jan 24, I reviewed notes and blood test to find that the patient had been discharged from Gloucester Hospital later on 2nd Jan with no blood test (blood calcium level) however Alendronic acid had been prescribed and the patient discharged with this on their discharge summary.	I telephoned patient at home and spoke to his wife. She tells me that Alendronic acid had been added to discharge summary however they did not send the medication as a TTO so she had procured some since. Patient has not yet started the medication. I have therefore advised not to until blood test taken. I have sent her a blood form which she is happy to arrange. Will await my feedback before starting medication.	Sent to Gloucester Royal Hospital for review	sent to Gloucester Royal hospital for review	Closed
GHC63688	04/01/2024	14/12/2023	23:59	Montpellier Secure Inpatients	Montpellier Low Secure Unit	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Haloperidol decanoate	No					Stat dose of prescribed Intra-Muscular Injection antipsychotic medication was not given within 72 hour timeframe. Patient was being augmented from oral to IM medication regime.	Medication error noticed on 4/1/24. Consultation with medical team, pharmacy. IM medication prescribed as stat dose, handed over to nursing staff for administration today.	Staff nurse who made the medication error emailed to complete a reflection on the incident.	POPAM guidance and checking using medication round tab.	Closed
GHC63717	05/01/2024	24/11/2023	14:00	The Vale Hospital	Vale Hosp- Peak View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Prescribing	Edoxaban	No					Patient was clerked by ward Dr. Ward Dr prescribed medication on system1 and prescribed 40mg of edoxaban orally. Phone call received from pharmacist to query dose and I also raised a concern with pharmacist as I knew edoxaban only comes in 30mg or 60mg tablets.	I looked back through patient's paper drug chart from Southmead Hospital and patient was prescribed 40mg Enoxaparin subcut route. I informed pharmacist of mistake and informed nurse on late shift to not administer edoxaban 40mg tablets orally and I crossed the dose off on system one to avoid a drug error. I asked nurse on late shift to administer Enoxaparin from paper drug chart. I tasked ward DR to change prescription. The following day 25/11 I informed ward Dr of drug error and asked Dr to change prescription. Ward Dr said the hand writing on paper drug chart was hard to read. I asked the ward Dr if she looked at the dose and the route as it said subcut and not oral. I also said to the Dr that Edoxaban only comes in 30mg or 60mg tablets and not in 40mg tablets.	Incident discussed with doctor at time. At time of incident it is felt that the handwriting on paper chart was poor and led to the error. Discussed with staff member that nursing staff had identified that dose did not match what they are used to administering and doctor admitted it was an error and apologised.	Work load and poor handwriting can lead to mistakes. Staff should continue to be alert to this and challenge or check any medication or dose they are not sure about.	Closed
GHC63719	05/01/2024	24/11/2023	08:34	The Vale Hospital	Vale Hosp- Peak View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Prescribing	Bisoprolol	Yes	1.25mg	1.25mg	NG/PEG/PEJ	NG/PEG/PEJ	When administering patient's morning medication on 24/12/23 I noticed that patient had an incorrect prescription. Ward Dr had started patient on a new medication - Bisoprolol on 22/12/23. The prescription stated patient was prescribed Bisoprolol 1.25mg tablets and the dose to be given was 125mg when it should have been 1.25mg. Patient had already been administered this medication the day before.	I informed the patient of the prescription error and verbal apology given to patient. I reassured patient that I was giving him the correct dose. I tasked ward DR to change dose of prescription to 1.25mg tablets. I spoke with the staff member who had administered the medication the day before and the correct dose was given to the patient. No drug error was made from the nursing staff.	Staff to continue to remember and use the 5 R's of medication administration and bring to the attention of the doctor any prescription that is unclear. This has been discussed with the doctor and they have reflected on their part in this incident.	To continue to use the 5 R's of medication administration. To continue to gently challenge and check prescriptions with prescriber if they appear unclear or unusual	Closed
GHC63722	05/01/2024	04/12/2023	10:00	Long Term Conditions	Heart Failure	Pharmacy-community	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Pharmacy	Losartan	Yes	50mg	omg	Oral		Patient had both entresto and losartan in dosette box and has been taking both for 5 days	called chemist- to advise of error- they will arrange for the losartan to be removed from the box. Called surgery to advise and ensure losartan has been removed from repeat. Patient checked own BP and bloods booked for Monday	Pharmacy/chemist contacted to advise of error Pharmacist will arrange for the losartan to be removed dosset box. GP surgery spoken to & advised and ensure losartan has been removed from repeat. Patient checked own BP and bloods booked for Monday	n/a	Closed
GHC63724	05/01/2024	05/01/2024	08:00	ICT	Reablement Forest	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Bisoprolol	No					When supporting the patient with their morning medication from their blister pack I noticed a tablet had been missed and not taken from the previous nights dose.	I spoke to my coordinator who advised me to speak to a district nurse. I spoke to one of the nurses who advised me to phone the GP to make them aware of the missed tablet. I phoned the Dr's surgery and made them aware and the GP phoned me back a little while late to advise that one missed tablet should be OK and to carry on with the medication as normal. I went back to the patients home to let them know what the GP had said and recorded in the notes.	MAR chart identifies Bisoprolol to be taken twice daily am and pm. medication progress notes on 4/01/24 indicates patient declined docusate from dossette evening of 4/2/24 but no mention of bisoprolol. would appears bisoprolol was missed in error. RA identified error morning of 5/2/24. Followed procedure, contacted GP and documented accordingly.	Medication error raised with RA line manager to identify learning to prevent this happening again. RA that identified error acted according to process, error was escalated per policy to ensure safety of patient. No harm caused.	Closed
GHC63726	05/01/2024	05/01/2024	12:22	ICT	ICT Chelt Town Centre DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administered when stopped	Administration	Dalteparin	Yes	5,000 units		Subcutaneous		- Upon checking patient notes, using 45 minute allocated time at start of shift, I noticed there was an entry from the GP on 3rd January 2024 saying to stop fragmin injections and that TASK sent to DN's. - I checked TASK's and I can see TASK reply from a GP on 3rd January 2024 directly to DN saying to stop Fragmin Injections. - DN's had visited on 3rd and 4th January 2024 still to administer Fragmin Injections, despite GP advising for them to be stopped on 3rd.	Informed triage nurse. Triage nurse advised I confirm with GP that Fragmin definitely to be stopped. Triage nurse advised I complete a datix. I confirmed with GP today about the injections and the GP replied to say stop fragmin.	2/2/24 Fragmin stopped after clarification form GP. Unfortunately GP replied to nurse directly on 3/1/24 5.30pm however she was not on duty until 5/1/24 so could not action it. Reporting clinician completed all appropriate actions & no harm to patient	2/2/24 When tasking if need reply before next on duty clinicians to advise GP to reply to referral centre so can be actioned promptly and all staff to ensure they use protected time at beginning of shift to review notes and forward plan accordingly	Closed
GHC63735	05/01/2024	05/01/2024	13:30	Complex Care at Home	Complex Care at Home Glos	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Missing medication	Pharmacy	Bisoprolol	No					On checking patient medication noted that bisoprolol not present in dosette tray. Date current on tray. Patient concerned that she has developed tremors. I noted that the patient has an irregular pulse (this is a pre-existing condition). Checked records and unable to see that this has been stopped, patient has been taking since September 2023.	Phone call to pharmacy - unable to get through - records on patient notes have incorrect number, unable to locate online either. Phone call to surgery to confirm if there is any reason that the patient hasn't got bisoprolol and to update GPs. Confirmed the patient should be taking. Visit to pharmacy - not able to explain why not in tray. New trays available for delivery on Monday - checked and bisoprolol present. Unable to deliver early as too late. Phone call to daughter in law who will consider if able to collect in person over the weekend. She will explain to her mother in law that the bisoprolol will restart with the next trays and this may help with her tremors.	Discussed with reporter. As soon as medication errors noticed reporter contact pharmacy and GP practice. Arranged for family member to collect missing medication before new dosette boxes made up for next delivery. No explanation why prescribed medication was missed by pharmacy, human error? Ongoing medication issues with this pharmacy. Other issues identified at follow up visit on the 22nd Jan 2024. Driver not available to deliver prescribed medications.	Comprehensive medication review identified error. Evidence of good practice by reporter. Risk of further error outside of GHC control.	Closed
GHC63782	06/01/2024	06/01/2024	20:27	Montpellier Secure Inpatients	Montpellier Low Secure Unit	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Paracetamol	Yes	1g	1g	Oral	Oral	A patient was given paracetamol 3 hours after the previous dose rather than 4.	Patient made aware of the mistake and apology was given.	Reflection completed by staff nurse.	Issues relating to EPMA in light of recent medication incidents to be communicated by Andy Gardner.	Closed
GHC63793	07/01/2024	06/01/2024	22:30	Wotton Lawn Hospital	Wotton Lawn-Abbey Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Monitoring / follow-up of medicine use	Other (unlisted)	No					Patient was observed to be storing medication in her mouth. The patient had said that she had swallowed her medication but the nurse was able to see that she had stored it at the side of her mouth and believed this to be from the previous time that she had taken medication. The patient was encouraged to spit it out onto a tissue which she did and then refused her new medication. During the process, it appears that the patient has been storing old medication as some was found to be in a tissue box.	The medication were taken from the patient and disposed of. The patient was then encouraged to let staff know any medication that she wants to take other than what is currently prescribed.	none	none	Closed
GHC63796	07/01/2024	06/01/2024	08:30	ICT	ICT Cotswold North DN	Pharmacy-community	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Ordering, collection or delivery	Midazolam	Yes	10mg	15mg	Subcutaneous		not enough stock of midazolam to replenish syringe driver at prescribed dose for a patient requiring end of life care.	care home staff were asked to collect stock from chemist when it opened at 0900 while i waited with the patient. unfortunately drug out of stock at chemist and would not be available until later that day. patient assessed and symptoms of agitation were not present. best interest decision made to replenish syringe driver with available midazolam that would be 5mg below dose and appointment made to return to patient as soon as further stock available to replenish syringe driver with full prescribed dose. decision communicated to nurse in charge who was in agreement with decision. care home staff fully aware of situation and advised to call DN service as soon as drug available or if concerns about patient. stock check made and recorded of all patient just in case medication.	Urgent plan put in place and the pharmacy ordered the medication as quickly as they could. Sensible plan of replenishing the driver with the stock available and a return visit planned to replenish again with correct dose organised. Patient was left with 24 hour observation and safety being in a residential home.	Plenty of stock to be ordered prior to weekends. Timely prescriptions and requests- communication with pharmacy if/whem ampules have a delay to order. Isolated issue as the team are usually hot on the above.	Closed
GHC63812	07/01/2024	07/01/2024	09:55	ICT	ICT Glos HQR DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Insulin aspart	Yes	20 Units	16 units	Subcutaneous	Subcutaneous	Wrong dose of insulin administered to the patient. Wrong patient box and drug chart handed to me by the care staff in the home. Inefficient bedside checks carried out, to ensure the drug chart was to the patient I was seeing. I thought I had been given the right box for the patient I was seeing and taken to. 20 units given instead of 16 units of the correct insulin prescribed for the patient. Error happened in the care home of the patient. contributing factors; Some interruption from carer during administration/checking process. Time constraints of completing insulin round on time.	Immediate escalation to my senior band 6 and advice from her followed. Error highlighted to the GP. Advice given to the carer to monitor the patient closely, encourage fluids and extra meal/snacks. Blood glucose level re-checked later and remained stable. Datix against the error completed the same day.	No harm to patient. altered from NEVER EVENT as was due to ineffective patient identity check against medication given. Nurse is currently in her probation period so very recently completed medicine management and insulin safety training.	Nurse has completed medicine management training and 6 steps to insulin safety. She has also completed supervised visits to gain competency. Nurse involved also wrote a reflection on the event to ensure that she had learnt from it.	Closed
GHC63820	07/01/2024	08/11/2023	09:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Co-beneldopa	Yes	125mg	125mg	Oral	Oral	During the time critical medication audit, it was identified that a patient's Parkinson's medications had not been signed until 10:30 when they were due at 09:00.	The nurse completing the medication round has been contacted to ask for explanation and to complete a reflection.	Reflection received from nurse demonstrating learning	None identified	Closed
GHC63822	07/01/2024	29/11/2023	09:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Co-beneldopa	Yes	125mg	125mg	Oral	Oral	During the time critical medication audit, it was identified that a patient's Parkinson medication was signed for at 09:30 when the medication was due at 09:00. There is no documentation on the notes explaining why the medication was given late.	The nurse has been contacted for an explanation and to complete a reflection.	Discussed threshold for this audit and should only trigger at 09:31. Reflection not required from staff member but reminded of need to administer time critical medication within expected timeframes and document reasons if not able to meet these.	None	Closed
GHC63849	08/01/2024	08/01/2024	08:45	ICT	ICT Forest South DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Insulin glargine	Yes	22 units	24 units	Subcutaneous	Subcutaneous	Attended for support with Insulin administration. Upon patient administering insulin the pen became jammed and struggled to administer correct dose of 24 units. Instead 2 units were remaining on pen so 22 units administered.	Discarded of pen and replaced with new one, ensured was working correctly. Reported to SCN Have booked appointment for CSN to visit patient later on today to check blood glucose.	15/01/2024 - Community Nursing Lead - Incident and notes reviewed - Correct actions taken by visiting nurse - Patient safety netted with additional call later that day to monitor blood glucose levels. - Insulin fault reported to MHRA via yellow card scheme	Thank you for your report - Correct actions taken by visiting nurse - Patient safety netted with additional call later that day to monitor blood glucose levels. - Insulin fault reported to MHRA via yellow card scheme - No learning identified	Closed
GHC63851	08/01/2024	07/11/2023	12:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Nystatin	No					During the missed dose audit for November 2023, a missed dose was identified during the lunchtime medication round.	As this nurse was an agency nurse, the clinical support manager for temporary staffing has been contacted to request a reflection from the nurse.	Reflection requested and not provided. Restriction placed on agency worker filling further shifts with the trust.	No further lessons identified	Closed
GHC63856	08/01/2024	15/12/2023	20:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Senna	No					During the Missed Dose Audit for December, a missed dose was identified during the 8pm medication round.	The nurse has been contacted in order to complete a reflection within 7 working days.	Reflection completed by nurse demonstrating learning from incident.	None further lessons identified.	Closed
GHC63858	08/01/2024	24/12/2023	21:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Other (unlisted)	No					During the missed dose audit for December, a missed dose was identified during a 9pm medication round.	The nurse has been contacted to complete a reflection within 7 working days.	Nurse completed relfection demonstrating learning	No further lessons learnt identified	Closed
GHC63885	09/01/2024	08/01/2024	17:50	ICT	ICT Forest North DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Stock balance recording errors / discrepancies	Morphine	Yes	7.5mg	7.5mg-10mg	Subcutaneous	Subcutaneous	Incorrect amount of medication recorded on JIC medication stock sheet. On documentation, it was documented that 1 ampule of morphine medication was in the JIC box, however, when I stock checked there was 6, and also a delivery had been collected in a sealed box and a sealed bag of 5 more morphine ampules - which equalled 11 in total before administering stat dose.	- re-checked all medication with CH - correct medication added to stock sheet - Care home stock book updated with correct amount of medication since delivery (Prior to delivery stock check it has been documentation 6 ampules of morphine in JIC box). - all documentation and stock check doubled checked with RN CH. - Message B6 for advise who advised to datix - All documentation on S1 -Datix completed.	- correct actions taken by the reporter - care home had received 2 prescription supplies of morphine and these had not been stored together - care home are now more vigilant with storing and recording controlled medications	- thank you for reporting this incident - no further action required	Closed
GHC63890	09/01/2024	06/01/2024	12:00	ICT	ICT Chelt Town Centre DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Insulin glargine	Yes	8 units	8 units	Subcutaneous	Subcutaneous	Insulin drug chart not signed. Drug chart in use 3-5th January with no doctor/prescriber signature.	Contacted lead nurse - informed not able to use chart. Due to weekend, given verbal order to administer insulin. Removed chart from property on 7th January, arranged for nurse prescriber to be re-written for Monday 7th January insulin visit.	Clinicians administering medication from incomplete prescription chart requested to reflected in a written format for manager to review. General documentation presentation delivered to all locality in team time the week of 08/01/2024	Clinicians under excessive prolonged amounts of stress due to service demand potentially impacting vigilance and care ability. service aware of impact of staffing issues and service remains on risk register as a result.	Closed
GHC63901	09/01/2024	09/01/2024	08:00	Charlton Lane Hospital	Charlton Lane-Chestnut Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administered when stopped	Administration	Chloramphenicol	Yes	1 drop	1 drop	Other	Other	Given patient eye drops medication its been discontinued since yesterday, there's medication prescribed as eye drops, mis-reading the correct medication.	Ward Manager inform and Doctors.	Appropriate action taken- staff to complete reflection on incident	NA	Closed
GHC63936	10/01/2024	02/01/2024	15:00	Crisis Resolution Home Treatmt	CRHT Cots & Vale	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Aripiprazole	Yes	12.5mg	10mg	Oral	Oral	Patient's chemi pack did not have prescribed 10mg Aripiprazole labelled on the pack so unable to ascertain what dose was in the chemi pack. Call to Superdrug pharmacy who advised that the dose in the pack was 7.5mg. Clinician obtained an FP10 for 2.5mg to make correct dose of 10mg and administered this to the patient alongside the dose in the chemi pack. When chemi pack was taken to the pharmacy the next day to obtain prescription labels, pharmacist checked the pack and advised that the dose in the pack was 10mg. Patient had therefore been given 12.5mg the previous day.	spoke with pharmacist involved gained advice from consultant of required follow up needed for patient after being given extra dose of medication	Staff encouraged to review POPAM All staff reminded of medication procedures for administration Staff took chemi pack back to the pharmacy and requested new labels with correct dose to avoid confusion in the future	None	Closed
GHC63937	10/01/2024	10/01/2024	08:55	ICT	ICT Glos North South DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Supply issue	Ordering, collection or delivery	Insulin lispro	No					Planned visit for morning blood glucose monitoring and insulin administration. On preparing insulin, only 6 units of medication left in disposable insulin pen. There were lots of insulin cartridges however not the correct reusable pen needed for administration. Therefore unable to administer morning insulin dose due to not having the correct equipment/ medication in patients home.	Blood glucose check completed, patient feeling well. Stock check completed and not the correct stock in home needed for administration. Contacted Band 6 nurse for advise. GP called and prescription for new insulin pen sent to pharmacy. We visited pharmacy to collect medication, however script hadn't been received by pharmacy. Patient had an outpatient appointment and had to leave at 9:45am, therefore we were unable to collect and administer morning insulin medication.	Thank you for submitting this datix. All appropriate actions taken at time of incident. I have discussed with CNL. - Supplies had been requested within a timely manner including pens 20/12/23 - This was then identified 3/1/24 as script having been done but not with all / exact items requested. Another email sent to chase but pens still not prescribed - Care plan started for weekly stock checks of insulin supplies - Message left for son to take away the cartridges from the fridge	This incident could have been avoided if: - Cartridges in fridge were to be removed from fridge initially - Proper stock checks had been in place including checking of scrips completed by surgery - Surgery had prescribed all that was requested Lessons learnt: - Ensure all insulin patients have a care plan for weekly stock checks to prompt / record this is being done - Ask family to remove any unnecessary equipment from home to avoid confusion - Clear communication with surgery when requests are being made (i do feel this was clear in this case)	Closed
GHC63943	10/01/2024	09/01/2024	11:30	Rapid Response & EONS	Rapid Response	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Adverse / allergic drug reaction (when used as intended)	Prescribing	Nitrofurantoin	Yes	100mg MR		Oral		Computer ran out of battery, unable to access patient records. Patient denied any allergies, interactions checked with medication at property. Antibiotic left with patient and son, advised not to start until they received a phone call to say it was safe to do so. On getting laptop working noted patient has sensitivity to given antibiotic- causes rash. Son contacted to advise not to start Antibiotic, had already given first dose.	Advised son of error and potential reaction, advised to monitor for swelling, rashes, difficulty breathing, skin flushing and call 999 if develops any of these symptoms and to contact RR when stable to make aware of situation. Advised would be returning to review and change ABX, not to give any further medication	issue recognised appropriate action taken immediately no effect on patient appropriate safety netting Review availability of in car laptop chargers	issue recognised appropriate action taken immediately, no effect on patient appropriate safety netting Review availability of in car laptop chargers	Closed
GHC63953	10/01/2024	10/01/2024	13:35	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong route	Administration	Glycerol	Yes	4g		Rectal		Patient due PRN Suppository due to constipation. Agency nurse asked patient to attend clinic and administered suppository whilst patient was stood up. Patient risk of falls, utilises walking frame - potential to fall/collapse. Patient distressed by this administration as reports nurse struggled to administer and then suppository fell out when patient took themselves to toilet.	Discussed incident with patient - apologised to patient for the method used and would followup with nurse. Patient accepted this resolution. Checked with nurse in charge if any concerns around practice of nurse - none identified. Was unaware nurse had chosen to administer suppository in clinic. Discussed with nurse involved, reported being unaware should ideally be administered laying down particularly with this patient group. Apologised and stated would amend practice for the future. Made aware would be reporting incident.	Followup being managed by staffbank including referral to NMC for agency nurse involved.	n/a	Closed
GHC63965	10/01/2024	10/01/2024	10:30	Working Well	Working Well-Occ. Health	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Administration	Hepatitis B vaccine	No					Nurse was working in vaccination clinic with a new member of staff observing and Nurse gave a vaccine that was not required.	Mistake explained to the individual that received the vaccine, and discussion around any risks involved and how the individual felt and line manager contacted.	discussion with Clinician a review of policy and procedures and a period of supervised practice and audit	further refresher planned in relation to vaccination in next clinical meeting along side 12/12 mandatory training	Closed
GHC63966	10/01/2024	03/01/2024	09:30	ICT	ICT Chelt Town Centre DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / omitted patient information leaflet	Information / advice to patients	Insulin glargine	No					I visited patient on 03.01.24 to administer two types of insulins Lantus 24 units and 6 units of Humulin I 1 when discovered that the Nurse who previously visited on 2.01.24, entered the wrong insulin(Semglee 24 units) on system one. However, the drug chart indicates the correct insulin unit for Lantus.	Assessed patient and he was well in himself. Reported the issues to the Manager via email and the Facilitator advised to write the datix. However due to capacity pressures and problems with datix accessibility i was unable to complete the datix on time.	Documentation error - incident reporter states correct insulin administered on paper drug charts. R/v S1 records which does state 'Semglee - 24 units' administered. I will discuss with RN who visited on this day for learning.	Staff to ensure documentation is correct and accurate	Closed
GHC63987	11/01/2024	11/01/2024	09:00	ADHD & ASC Countywide	ADHD Adults Team	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Ordering, collection or delivery	Lisdexamfetamine	No					Prescription posted to nominated pharmacy before BP was checked. Patient has prescription and we have contacted the patient to request they call our serivce	Patient has prescription and we have contacted the patient to request they call our serivce. Pharmacy called to confirm receipt of prescription	none	none	Closed
GHC64029	12/01/2024	08/01/2024	13:15	ICT	ICT Chelt Peripheral DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Prescribing	Dexamethasone	Yes	500mcg		Subcutaneous		Arrived at patient's house to replenish syringe driver pump. Noted the drug chart on the Dexamethasone had not been signed or dated by the prescriber. The drug chart had been signed for and administered each day by a nurse setting up the driver.	Called nurse prescriber on duty Band7 to ask for a verbal prescription today, so not to delay treatment. Asked for a nurse prescriber to rewrite a new chart. Photo taken of the drug chart error and sent to the Band 7	All staff whom administered and therefore made a drug error requested to review medications management and written reflection of learning to be sent to CNL for their team. team time for all locality on documentation presentation formulated by CNL's and learning exercise 'spot the errors' participated in by all staff.	Danger of 'copy' culture and task orientation in busy periods of service demand. Patient care can not be compromised as a result of organisational pressures.	Closed
GHC64055	12/01/2024	29/12/2023	22:00	CYPS/PH Community Specialist	CYPS/PH-Children Complex Care	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Clobazam	Yes	0.75mls	0.5mls	NG/PEG/PEJ		Medication given not following the weaning regime provided by hospital on discharge, identified by child's mother	Weaning chart now not relevant as further admission led to another change in dosage. Medication administration record rewritten using discharge summary and with confirmation from mum that doses correct. Manager informed by email and team informed via child's carers Teams group	Medication charts have been reviewed. Team made aware at team meeting Next team meeting - section on MARS charts to be delivered to staff	Thank you for reporting this	Closed
GHC64102	14/01/2024	11/01/2024	12:00	ICT	ICT Glos HQR DN	Self-care	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Information / advice to patients	Morphine	Yes	180mgs	0mgs	Other	Not applicable	Patient was commenced on a syringe driver on Wednesday 10th January with advice from Palliative care nurse. Patient and wife were advised to omit his MST following syringe driver set up as he would have the same amount of morphine in his pump. On arrival at patient on Thursday 11th January, wife met me at the door and advised that something was wrong. Patient was not in pain but appeared to be confused and drowsy. On discussion with patient he admitted that he had taken his MST on the evening of the 10th Jan 90mg and the morning of the 11th January 90mgs.	Patient observations taken and resp rate was low at 10 originally but after verbal stimulation patient was rousable and able to have a contextual conversation. Patient resps increased to 12 at this time. Specialist palliative care nurse joined me at the visit and was happy to amend the syringe driver pump and we advised that wife took over the administration of oral medications to save confusion and she wrote this down. Patient was more alert on leaving. Later that evening Patient's wife rang me with concerns that patient's breathing had changed. She was able to follow my instructions to count breaths in 1 minute and told me that they were 5 breaths per minute. I advised her to call an ambulance. Paramedics called me to say that patient was rousable and they monitored his obs for 30 minutes. They advised wife to call DN's overnight with any concerns. OOhs visited at 4am and stated patient was confused and had pin-prick pupils. On my visit later that day pupils were reacting and equal and size 3. Patient remained confused and generally unwell. It was felt between myself, GP and	This event occurred due to the patient not following the advice given around medication and subsequently overdosing on his opioid analgesia. This was unfortunate and the wife consequently took over management of his medication. The patient was deemed to be end of life and did pass away in a hospice relatively soon after the incident.	This highlights the need to ensure clarity in understanding- but also to ensure the patient is well enough and has capacity to follow through on instruction given.	Closed

GHC64121	14/01/2024	14/01/2024	18:00	Recovery Units	MH IP Rehab-Honeybourne	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Use / possession of over-the-counter (OTC) medicine	Co-codamol	No					House keepers found an empty Co-codamol 30mg/500mg tablets strip in a patient's bedroom and it was decided in handover to search his bedroom. Patient was told about the plan and he readily agreed to give staff a box of Co-codamol 30mg/500mg. He then advised that he did not have anymore medication on him. He said he has been using this medication for pain management in between what he gets in the clinic and the pain medication he is getting in the clinic has not been enough to keep the pain under control. He stated that the doctors will not provide him with sufficient painkillers. He was starting to get more hostile and defensive while repeating that the doctors wouldn't give him enough medication, so staff disengaged.	Staff pressed that a room search was needed and a further strip with 10 tablets was found in is drawers. In total 70 tablets of Co-codamol/30mg/500mg tablets were found on him and empty strips, which had a total of 40 tablets used.	Patient reviewed by consultant who looked at risks Pain relief reviewed and adjusted	None	Closed
GHC64125	15/01/2024	14/01/2024	03:39	Tewkesbury Hospital	Tewk Hosp-Abbey View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug administered when stopped	Administration	Oxycodone	Yes	2.5mgs	2.5 mgs	Oral	Oral	During the hourly rounds, patient called the attention of one of the HCA and verbalised that she is in pain.	Staff Nurse SH came to see the patient as Staff Nurse JN was on her break. Patient was crying due to severe pain on her left leg. Patient has been taking Oxynorm previously and this is known to Staff Nurse SH. Staff Nurse SH had quick glanced at the drug chart in SystemOne, but missed the fact that it was discontinued during the day. Staff Nurse SH administered Oxynorm 2.5mgs/2.5mls orally. When Staff Nurse JN came back from break, she signed the CD book without double checking the prescription. Medication error was discovered when Staff Nurse JN was about to sign the medication chart in SystemOne, and found out that Oxynorm liquid has been stopped. Patient has received Peptac at the same time with Oxynorm to counter-act indigestion effect. Patient have settled after that. And no further complaints of pain nor indigestion in the morning. Verbal apology given to patient in the morning. Patient said it was not our fault as she did asked for it. Senior Sister SR was informed of the incident. Patient was reviewed, nil effect from the in	Discussed with Both staff members involved, reflections completed, Both staff members have repeated the administrations of medicines, management of controlled drugs, reread the CD policy and made sure all medication SOP's have been read and signed. Duty of Candour followed.	Both staff members understand the importance of following policy and procedure, the ward was very busy at the time they both understand that no matter how busy they will be more vigilant when completing medication rounds and not get distracted.	Closed
GHC64147	15/01/2024	13/01/2024	11:30	Rapid Response & EONS	Rapid Response	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Prescribing	Ceftriaxone	Yes	2g		Intravenous		On above date patient administered Ceftriaxone for ? chest infection on verbal order from RR Band 7 prescriber. Documented by myself on System 1 that verbal order had been given but not independently documented by prescriber. On 15/01/24 2nd dose Ceftriaxone administered to the same patient based on patient presentation and inability to take oral meds. Fluids had been written up on chart by prescriber but not Ceftriaxone so i incorrectly documented the Ceftriaxone doses on the front of the chart as having been given on PGD despite having no PGD for Ceftriaxone for chest	Discussed with Band 8a who was happy that Ceftriaxone was administered on a verbal order based on clinical presentation and lack of oral route. Discussed confusion around verbal orders and remote prescribing	No further action required	All staff reminded of section 2.1.11 of the POPAM policy for Remote Prescribing	Closed
GHC64154	15/01/2024	15/01/2024	20:15	District Nursing (ENDS)	ENDNS- Out of Hours DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Midazolam	No					- ENDNS visit for symptom control due to pain. - Patient is receiving end of life care at home and is on a syringe driver. - Presenting complaint is pain, so morphine stat dose administered as prescribed. - Stock check completed and eight ampules of midazolam 10mg in 2mls missing and not accounted for.	- Informed patients two daughters who were present throughout visit and not aware of where else it could be. All DN equipment stock, s/driver box etc checked, searched kitchen and lounge but not found. - Advice given to daughters re contacting ENDNs if needed overnight. - Contacted and spoken via telephone to Day DN who visited earlier this morning. (More medication already ordered) - Informed ENDNS shift lead via telephone call. - Datix completed	extra vigilance surrounding medication stock checking. No obvious concerns regarding symptom misuse for patient or family.	all clinicians advised to ensure opening all boxes when stock checking incase of any initial pharmacy discrepancies.	Closed
GHC64178	16/01/2024	16/01/2024	14:15	Cirencester & Fairfrd Hospital	Ciren Hosp- Coln Ward	Pharmacy-provider	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Pharmacy	Duloxetine	No					Patient medication came in bag with a label for patient on coln on the outside bag, and label for patient from north cots medication inside.	Escalated with pharmacy, apologies received. To give the medication to the transporter in the morning. I have let north cots know about the med error.	ward pharmacy team aware to investigate	good observation and medication checking on receipt of pharmacy	Closed
GHC64186	16/01/2024	08/01/2024	14:00	ICT	ICT Chelt Peripheral DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong / unclear dose or strength	Administration	Buprenorphine	Yes	5mcg/ph	10mcg/ph	Topical	Topical	incorrect dose of Bunov patch applied, patch applied 5mcg/ph instead of 10mcg/hr incorrect medication in the house no 10mcg/ph patches in property	Patch removed on due date x2 patches applied and 10mcg/ph patches ordered for next visit	- Staff member applied x2 patches to ensure correct dose administered -Correct dose of medication requested from GP surgery -Discussion had with member of staff who had seen patient on previous visit - Reminded staff during team time to check drug charts and medications they are administering	- Make sure correct dose of medication in property and medications ordered in plenty of time - Staff to check 5 Rights before administering medications	Closed
GHC64194	16/01/2024	16/01/2024	20:00	Cirencester & Fairfrd Hospital	Ciren Hosp- Coln Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Gabapentin	Yes	1200mg	1200mg	Oral	Oral	2200hr gabapentin given at 2000hrs	Apologies given to patient Observations taken news 1 as pulse 46 Night team informed	staff flowed correct response ward manager spoke to patient the next day and explained and apologised	staff to be aware that although a 2nd signatory is not required for a schedule 3 as not a CD the 2nd countersignature is still accountable to check the drug chart and times etc also staff to check if a pop up alerts a incorrect drug administration time	Closed
GHC64211	17/01/2024	17/01/2024	12:00	Wotton Lawn Hospital	Wotton Lawn-Dean Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Prescribing	Sodium valproate	No					I was completing the pharmacist medications pending verification check and noticed that a patient had been prescribed Epilim. This medication should have been prescribed for a different patient on the ward. Medication was prescribe today (17/1/24) with a start time of 22:00 so no valproate had even had the opportunity to be administered to the patient.	Checked RiO, contacted Dr who prescribed the medication and discontinue the prescription on RiO	Prescribing error, for medical team to manage No mention on Rio regarding near miss, I have little information to enable review, unaware of incident of Datix until now No harm caused	Incident should have been flagged with medic at time of incident for protocol to be followed and action/learning achieved	Closed
GHC64289	18/01/2024	17/01/2024	12:00	Recovery	Recovery Tewkesbury	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Supply issue	Ordering, collection or delivery	Zuclopenthixol decanoate	Yes	500mg	500mg	Intramuscular	Intramuscular	When reviewing the community depot stocks, it was noted that there was a stock error of 5x500mg Zuclopenthixol Decanoate that was not accounted for (i.e. one stock box was missing). After cross referencing to the community depot charts it was discovered that a stock box (not labelled) was given to a community nursing home for use for a GHC patient. This is a regular supply as the patient's GP refuses to prescribed the depot. However on this occasion the zuclopenthixol decanoate was not ordered from GRH dispensary against a community prescription but was supplied from the community team stock against an out of date prescription. The medication was delivered to the care home on 6/9/23 prescription chart was dated 13/12/22. No indication on prescription that medication had been supplied. There was however a note on RiO detailing the supply. This contravenes the Medicines Act.	Discussed incident with team manager. Team manager sent email to the team to remind them of medicines management within the team. The issue will be discussed with the team and additional support provided if required.	lead pharmacist review the systems and nurses had a refresher of the POPUM guidance	as above lessons are about accuracy	Closed
GHC64293	18/01/2024	21/12/2023	17:00	Eating Disorders	Eating Disorder Community	Pharmacy-community	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Pharmacy	Potassium bicarbonate + Potassium chloride	Yes	2 tablets 3 times daily		Oral		I received a message from EDS (Eating Disorders Service) Phlebotomist on 17/01/24 advising that the patient would like clarification about medication recently prescribed as their home GP had informed them they had been given the wrong medication. The patient had been prescribed Phosphate Sandoz x2 tablets 3 times daily by an EDS Dr following low phosphate in blood tests. This prescription had been provided on 21/12/23 and started the same day and had then been reduced to x1 tablet 3 times daily on 09/01/24 following an improvement in blood tests as per instruction from the EDS GP. In conversation on 09/01/24 with me the medication and dosage was confirmed before advising of the change and the difference in medication was not reported by the patient or their father. In retrospect the patient and their mother remembered being confused when they first received the medication. In discussion with the patient and their mother on 17/01/24 I confirmed that	On 17/01/24 I advised the patient to stop taking SandoK immediately. I reviewed documentation and discussed next steps with the EDS GP. RIO notes and a scan of the paper prescription uploaded to RIO confirmed that Phosphate Sandoz had been prescribed correctly by the EDS Dr. Blood tests showed a rise in potassium whilst SandoK was taken, but always comfortably within range. The patient did not describe any signs of ill health. I cautioned the patient's mother to seek an immediate medical review if the patient experienced any change to physical health and informed her that although blood tests indicated potassium had remained within the normal range, high potassium can adversely affect the heart. I apologised to the family that an error had been made by a health care provider. I advised that I would be reporting the incident and would contact the Pharmacy so that they could do the same. Blood tests had been taken the morning of 17/01/24. These were reviewed same day and were all in range. This was communicated to the patient and	highlighted with medical director	highlighted with medical director.	Closed
GHC64311	19/01/2024	04/01/2024	11:00	Later Life	Later Life Gloucester	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Paliperidone	Yes	not sure	75mg	Intramuscular	Intramuscular	CMHN gave IMI palperidone 75mg to patient however the medication squirted out from the connection of the needle to the syringe , so patient did not receive full dose and and I was unable to ascertain how much was given to the patient.	i did not inform patient of the incident and felt that this would be detrimental to her mental health as she already has reservation of taking the medication and its effects .	reported to Pharmacy and consultant	staff reminded to check the pre filled syringe and needle before administering	Closed
GHC64312	19/01/2024	18/01/2024	14:45	Later Life	Later Life Gloucester	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Preparation by administering clinician(s)	Risperidone	Yes	1.5mg	1mg	Oral		Pt had not had mental health medication for several days family advised as there was a supply issue with the chemist. As a result pt was extremely agigtated and driven, presented as paranoid and had been in the garden in extremely cold temperature with inadequate clothing. once inside continued to be physically threatening, tried throwing a chair. Requested daughter obtain the risperidone 0.5mg liquid (pt px 1mg) Due to stressful situation daughter drew up the wrong dose, nurse administered it aprox 1.5mg . Pt spat out the medication in to his open fire, could here it sizzle. Paramedics arrived at the property and checked him over (pre-arranged by gp)	CMHN contacted office and advised senior nurse in the team of above incident	daughter support by the team advised consultant and pharmacy of the error	advised and support given to carers in relation to medications	Closed
GHC64318	19/01/2024	18/01/2024	10:30	Wotton Lawn Hospital	Wotton Lawn-Abbey Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong formulation	Administration	Estradiol	No					A morning shift nurse found Patient A's medication in Patient B's room on their bed.	This was removed from the room and destroyed.	No further actions at this time	No further considerations of lessons learnt at this time	Closed
GHC64320	19/01/2024	19/01/2024	08:35	ICT	ICT Chelt Peripheral DN	GP	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Information / advice to patient not given / wrong	Monitoring / follow-up of medicine use	Other (unlisted)	No					Went to GP surgery to collect Insulin drug chart for patient. 2 Drug charts completed but both different dates and both completed by different GPs. First drug chart stated insulin units needed to be increased by 2 units, which dated 12/01/24. The second drug chart stated same units as patient is currently on which is 24 units, dated 18/01/24. Did have a look on SystmOne but no documentation from GP regarding any drug chart being updated.	Went back into GP surgery to be informed by receptionist who spoke to GP the first drug chart was an error on their behalf and for patient to stay on units currently on.	Appropriate action taken at time of incident: - Datix completed - Concern escalated to Senior Colleague - Change in dose queried with GP before medication administration - Correct medication chart obtained	- Case on a page created to share at team time - Staff to continue to diligently check medication charts before administering medication and if they are not correct/not fully completed, this should be raised and correct prior to giving medication.	Closed
GHC64341	19/01/2024	19/01/2024	11:40	ICT	ICT Chelt Town Centre DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Cyclizine	Yes	50mg	50mg	Subcutaneous	Subcutaneous	Visited patient to administer stat doses. Stock sheet stated 7 ampoules of cyclizine but carers could only find 4. Only 2 stat doses given previously from drug chart and S1	Asked carers to double check medication cupboard but they couldn't find them GP ordered more medication	Discussed with care home to ascertain if ampules were found. Senior carer reports they were not. Asked to ensure they are locked in secure cabinet and to keep stock sheets up to date with DNs or GPs visiting.	Stock sheets to be completed and checked at every DN visit and any GP visits to be documented incase stock used.	Closed
GHC64348	19/01/2024	11/01/2024	13:50	ICT	ICT Chelt Peripheral DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Apomorphine	Yes	50mg/10ml		Subcutaneous		Visited patient to replenish APO pump. When I went to sign drug chart, there were no spaces left to sign.	Took photographs of drug chart. Checked S1 - no documentation of drug chart being requested by GP or nurse prescribers. Uploaded photographs to S1. Called B7 nurse prescriber to ask for new drug chart to be written out. Added note to next visit to take in new drug chart. Created time to complete datix.	- New medication chart written up by prescriber - Incident appropriately reported - Reflective discussion facilitated with colleague reporting and reflective account to be completed as it was identified that a new chart could have been completed in advance	- Reflective discussion also to be facilitated with team at team time as it is a whole team responsibility to identify such issues and action accordingly, rather than leaving until the last minute	Closed
GHC64365	20/01/2024	20/01/2024	10:30	PICU	Wotton Lawn-Greyfriars PICU	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Aripiprazole	Yes	20mg	10mg	Oral		Patient agreed to accept his prescribed oral 10mg Aripiprazole and 50mg Promethazine this morning. Initially he was very suspicious around the Aripiprazole tablet (colour and size) and therefore staff agreed to show patient the box, his prescription and tablet. Nurse dispensed an additional tablet into his medicine pot so he could compare the two. He was about to take all of the meds but was advised by staff that he did not need both Aripiprazole and to remove one. Before we reached the end of our sentence patient took all tablets. He was advised that he had taken 10mg too much to which he responded "I take 400mg depot each month so am sure 20mg will not hurt me".	Duty doctor contacted to be made aware - no concerns as within daily limits.	Duty doctor contacted and advised that the patient had taken more medication than prescribed, no concerns raised as doseage within safe treatment range. Nursing staff maintained vigilance of patients mental and physical well-being to observe for any adverse reactions. Patient made aware of medication error.	Incident discussed in nursing handover to ensure a situation like this does not occur in the future.	Closed
GHC64417	21/01/2024	20/01/2024	08:30	ICT	ICT Forest South DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Morphine	Yes	15mg morphine	5-10mg of morphine	Subcutaneous	Subcutaneous	Visit to palliative patient for urgent stat doses for pain and aggitation. On arrival noted that stat doses of Morphine sulfate and Midazolam were given at 22:00 in the night but were given off the syringe driver section of medication chart. Had 15mg of morphine instead of 5-10mg on stat dose section of drugs chart.	Patient in pain and aggitated so stat doses administered on my visit. Informed my shift lead and she contacted palliative care team for advise about managing her pain and aggitation levels.	Staff member supported with all required actions following medication incident. Discussion with staff, verbal and written reflection completed. medicines management modules completed and attended teaching session on medication administration, participating and contributing to discussions. Supervised visits undertaken and competency sign off and positive feedback achieved. Further discussion with staff member showed their learning from incident and assessed as competent to visit unsupervised.	Importance of paying attention to medication chart, having area free from distraction to concentrate and not feeling rushed or pressured by patient/family as this may impact on safe administation. Reflection on incident and following discussions and teaching session showed learning from incident.	Closed
GHC64448	22/01/2024	22/01/2024	09:05	Wotton Lawn Hospital	Wotton Lawn-Abbey Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong route	Preparation by administering clinician(s)	Lorazepam	Yes	2mg	2mg	Intramuscular	Oral	Patient presenting as agitated and hostile, patient verbally threatening towards staff, as well as kicking out, patient also pushed over peer unintentionally but causing harm. RT IM given to help manage presentation on the ward. On checking chart post administration it became apparent that RT was only prescribed PO.	Patient offered opportunity to engage in debrief, patient hostile and abusive throughout, offered PRN prior to incident declined. Decision made to give RT, nursing staff error in checking prescription. Duty Dr informed of error, patient observations commenced as per RT policy.	Med error protocol implemented	Feedback to the team will occur during next few staff meetings in relation to thoroughly checking route of RT	Closed
GHC64450	22/01/2024	22/01/2024	08:00	Wotton Lawn Hospital	Wotton Lawn-Dean Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Ordering, collection or delivery	Other (unlisted)	No					Patient did not receive prescribed Aymes shake due to it being unavailable.	Staff informed patient of issue staff asked other wards to see if they had any Staff ordered medication via pharmacy	Nursing staff reminded to check all prescriptions and ensure medication is ordered in timely manner Nursing staff reminded how to obtain prescriptions out of hours	Staff to follow POPAM and ensure medications are ordered and available when needed	Closed
GHC64477	22/01/2024	21/01/2024	20:52	Psychiatric Liaison	MH Liaison Acute Hospitals	GP	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Adverse / allergic drug reaction (when used as intended)	Administration	Sertraline	Yes	25	25	Oral		suspected sertraline induce manic symptoms.	999 called and bought into hospital Yellow card alert on MHRA webside	Appropriate review and potential issue identified, yellow carded and reported. Apporirate F/u arranged	It is important to remain mindful of the impact of new medication on a presentation and for this to be assessed routinely, as in this case as part of the presenation	Closed
GHC64486	22/01/2024	22/01/2024	21:15	Montpellier Secure Inpatients	Montpellier Low Secure Unit	Pharmacy-provider	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Valproic acid	Yes	750mg	750mg	Oral		Staff nurse was dispensing Valproic Acid and discovered the box was labelled incorrectly. The label states 250mg tablets but the actual tablets are 500mg. Staff nurse discovered this before the patient received their medicine. Patient received the correct dose.		Pharmacy investigation: ward provided photographs as evidence that 250mg label was on box of 500mg tablets. Dispensing and checking error - staff involved to complete reflections. Error to be shared at team meeting. Ongoing work within pharmacy to minimise distractions.	as above	Closed
GHC64520	23/01/2024	16/01/2024	09:20	CYPS Management & Admin	CAMHS - Admin	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Controlled stationary (medication related)	None (no harm caused by the incident)	Missing medication	Pharmacy	Methylphenidate	No					Received a telephone call from Pharmacy advising that they had not received the original prescription dated 29/12/2023. They had received the email version but needed the original. I apologised for this.	I said that I will get another prescription written and will email them the new prescription and post the new prescription.	Request for E prescribing	Once mail leaves the site it is outside of our control. E prescribing would reduce risk of lost scripts	Closed
GHC64603	25/01/2024	24/01/2024	21:45	Recovery Units	MH IP Rehab-Honeybourne	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Quetiapine	No					Patient had self medication in their room. A reduction had been implemented in MDT earlier in the day. Patient took previously prescribed dose of medication.	Discussed this with patient. They stated they were not aware of the change taking place that evening, thought this was the following day. Patient has no more medications on their person. Documented on rio.	Agreement with consultant to start new meds with sufficient warning to allow new doses etc to be ordered	As above	Closed
GHC64615	25/01/2024	25/01/2024	08:00	Lydney Hospital	Lydney Hosp-Lydney Ward	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug has expired	Administration	Sodium valproate	Yes	500mg	500mg	Oral	Oral	patient transferred from acute trust on evening 23rd January with supply of medications and paper drug chart on attending to administer morning medications noted that sodium valporate was prescribed however he had came with epilim Chrono (modified release) also noted that this medication had an expiry date of 01.2023.	medication removed from patient locker and disposed of, explanation of findings given to patient and apology given that this had happened. emergency order placed with pharmacy and delivered by 10:30 so morning dose only delayed by 2 hours. medical team aware, monitor for new seizure activity staff members here that had administered doses yesterday to be spoken to regarding error and to reflect on this. reminder around checking meds added to safety brief	medication removed from patient locker and disposed of, explanation of findings given to patient and apology given that this had happened. emergency order placed with pharmacy and delivered by 10:30 so morning dose only delayed by 2 hours. medical team aware, monitor for new seizure activity staff members here that had administered doses yesterday to be spoken to regarding error and to reflect on this. reminder around checking meds added to safety brief	reminder around checking meds added to safety brief correct actions taken by incident discoverer escalated to GHT	Closed
GHC64618	25/01/2024	25/01/2024	11:15	CLDT	LD Community Nurse training	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Medication storage issue	Storage	Zuclopenthixol decanoate	No					11 ampoules of Zuclopenthixol Decanoate 200mg in 1ml missing from Gloucester CLDT drug cupboard. Documented on 16.01.2024 in Gloucester CLDT's Medication Stock Record that there were 21 ampoules of the above drug in stock. This morning 25.01.2024, I remember seeing the four boxes of Zuclopenthixol Decanoate 200mg in 1ml in the drug cupboard when I went to physically take another client's depot off the shelf. I left the clinic room at 09.30 hours approximately to return to the third floor where CLDT is based, and left Pullman Place at approximately 10.00 hours to administer the client's depot and returned around 11.20am to replace the client's drug chart in the drug cupboard when I noticed that there was one box of Zuclopenthixol Decanoate 200mg in 1ml left with 10 ampoules in the box.	1. Physically searched the whole of the drug cupboard looking the missing 3 boxes of ampoules 2. Asked the CLDN of the client who is prescribed the Zuclopenthixol Decanoate, if he was aware of the missing ampoules, he was not. 3. Asked a fellow nursing colleague to search drug cupboard for missing ampoules for me in case I did not see them, not found. 3. Asked IHOT deputy manager if ampoules were in their cupboard. As on occasions IHOT will step in for CLDT if a depot needs doing and a CLDT nurse is unable to administer. Deputy Manager physically checked the IHOT drug cupboard, ampoules not found. 4. Informed Team Manager of missing ampoules. I was advised to contact Karen Page - MH Pharmacist - to see if a pharmacist had been into clinic room at Pullman Place to audit et cetera. I was informed that this had not been the case, and advised to complete a datix 5. Informed Gloucester CLDT team manager of the advice that I had been	The other team who share the cupboard had removed it back to their shelf. They had counted the medication in on their records when it first arrived and realised it had been moved. Incident reporter who had done a stock count added it CLDT records previously. She is trying to tidy up medicine recording file. Unfortunately the other team didn't tell us they had done that until much later in the afternoon, by which point the Datix had been submitted. I had requested reporter check with them before submitting the Datix as she had noted they had some but this hadn't happened.	Now exploring the possibility of sourcing a separate cupboard to avoid confusion. Process for recording stock levels are being looked at by the team Medicine Link Worker and require some finessing. This is in progress. Incident shared with the qualified nurses	Closed
GHC64657	26/01/2024	06/01/2024	10:00	ICT	ICT Chelt Town Centre DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Insulin glargine	Yes	26?	24	Subcutaneous	Subcutaneous	Insulin chart - noted incorrect dosage signed for on dates 21/1/24, 22/1/24, 23/1/24 - error from 21st copied through dates. Prescription for 24 units ?was 26 units given on the 3 dates. S1 documents correct dose but ?copy/paste. Differing doses documented on S1 to chart.	Checked front of chart for correct dose, signed for correct dose. Correct dose given. Informed RN Manager following visit.	discussion with clinicians involved. written reflections requested and re review of medications management.	Forced errors increasing at times of excessive service demand. demonstrated via active risk assessment.	Closed
GHC64663	26/01/2024	24/01/2024	00:00	Sexual Health Service	Sexual Health Integrated ISH	Pharmacy-provider	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong formulation	Pharmacy	Nystatin	No					Patient phoned Hope House after collecting medication from Pharmacy provider on 24.1.24. The medication she was expecting had been dispensed in a liquid form and should of been a vaginal tablet as she previously had. The Pharmacy dispensing label had no contact number on so she was unable to ring them to check what was on the prescription so rang Hope House instead.	I phoned Pharmacy provider - staff member located the prescription and apologized as vaginal tablets should of been dispensed. Pharmacy provider requested liquid medication to be returned and the vaginal tablets will be dispensed. I informed patient who will collect supply next week	Discussed with both Pharmacy Manager and the prescriber as omission of dose form on prescription was not queried and led to dispensing error	Clarification of incomplete prescriptions required	Closed
GHC64668	26/01/2024	25/01/2024	15:30	Wotton Lawn Hospital	Wotton Lawn-Kingsholm Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Prescribing	Lorazepam	No					During consultation with SOAD regarding patient on Kingsholm ward, it was flagged that the patient had been prescribed 1-22mg lorazepam IM as rapid tranquilisation. Max licensed dose for this is 4mg/day. This was prescribed for 8 days before the error was noticed. The ward pharmacist did not spot this error. No doses were given. SOAD explained that the nursing team were aware of the mistake but it had not yet ben rectified.	Confirmed with ward drs that the prescription has been amended, and that no doses had been adminsitered. Datix copmleted.	Nursing team and medics check all prescriptions in ward rounds with patients and nursing staff to check all prescriptions during medication administration to flag issues as early as possible.	For all clinicians to check prescriptions and report errors/glitches as soon as possible.	Closed
GHC64685	26/01/2024	26/01/2024	12:00	ICT	ICT Chelt St Paul's DN	GP	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Prescribing	Dalteparin	No					Telephone call received from Band 4 colleague to advise that a GP had requested fragmin administration due to deranged INR. Medication chart for fragmin in home however prescribed on an anticipatory medications chart rather than a community prescription chart. Incorrect chart has been used and signed by several employees to administer and therefore have not requested a new chart.	Datix completed Correct chart requested from GP so that fragmin could be administered later today	29/1/24 All appropriate actions completed . Staff to ensure they use the correct charts for medicine interventions. B6's to discuss in team time correct use of charts as per guidelines.	29/1/24 Staff to ensure they take time to double check drug charts prior to interventions & ask advise if any concerns	Closed
GHC64699	26/01/2024	26/01/2024	15:35	ICT	ICT Cotswold North DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug has expired	Administration	Glycopyrronium bromide	Yes	200mcg		Subcutaneous		Visit to assess EOL patient, given glycopyronium for secretions. Error as thought date was 2024 exp but actually was 1 month expired upon giving. Dated 12/23. Informed carers and ordered new medication and advised to dispose of expired ones. DOC completed		Nurse has reflected on medication error, no further action required	Continued vigilance when checking expiry dates on medications	Closed
GHC64725	27/01/2024	26/01/2024	20:00	Stroud Hospital	Stroud Hosp-Cashes Green Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Administration	Morphine	Yes	5mg	5mg	Oral	Oral	Came to give Morphine 5mg to patient. I used 5mg liquid morphine where the prescription said modified release tablets. I made a mistake. I had gone back to double check when it asked me to counter sign on System one, where I rechecked the drug I was giving was corrected, and the dose was correct 5mg. However I had missed that the drug was modified release and tablet form.	I reported to the Sister on shift and marked the due medication as in error. I then tasked the Dr to inform. I also handed over to the night staff that I had made a drug error and that the patient may be in pain during the night as they had not had modified release	Please see progress notes. Reflection uploaded.	RGN reminded of our duty to include patients and their families in incidents and to apologise for errors that occur under our care.	Closed
GHC64755	28/01/2024	28/01/2024	11:45	Wotton Lawn Hospital	Wotton Lawn-Abbey Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Information / advice to patient not given / wrong	Monitoring / follow-up of medicine use	Other (unlisted)	Yes	N/A		Oral		Unidentified medication found in the male corridor on the floor	Staff removed it. Multiple staff members attempted to identified it, with no success. Medication disposed in the blue bin.	No further actions taken at this time	No further considerations around lessons learnt at this time	Closed
GHC64756	28/01/2024	23/01/2024	12:00	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Monitoring / follow-up of medicine use	Dalteparin	No					Patient was not administered fragmin injection on 23/1/24. Patient requires injections when INR below 2.5 which INR was - however no appts booked for daily injections until next INR.	Surgery informed DN's of next INR date and I thereofre picked up patient should be having daily fragmin so all booked in.	- Appropriate escalation at time of incident. - GP has since reviewed and patient has now been given correct care and treatment. - Follow up booked - No harm caused to patient.	- Learning to be shared with wider team regarding follow up and booking ongoing appointments.	Closed
GHC64757	28/01/2024	27/01/2024	15:00	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Medication storage issue	Storage	Hydroxocobalamin	No					cleaning out the Syringe driver cases, noted a sealed box of Hydroxocobalamin 1mg in the bottom of the case	medication removed and disposed of at Boots the chemist Shift lead informed	Appropriate action taken no harm caused. Reminders sent to staff.	Reminder sent to staff to check syringe driver boxes before removing from the house to ensure no medications left in the box. Reminded of responsibility of families to return medications to the pharmacy.	Closed
GHC64761	28/01/2024	26/01/2024	09:00	Nursing Leadership	Nursing Profession Leadership	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Fentanyl	Yes	25mcg	25mcg	Other	Other	patient prescribed to have fentanyl 25mcg patch applied every 72 hours, i didnt realise this on the cp so it was missed on the date it was meant to be renewed (26/01/24)	when realised this should have happened on 28/01/24 @ 9am, checked cp explained to patient, apologised and applied new patch as per cp. 48 hours late. patient stated she was unaware she had one on initially.	Patient medications reviewed, MAR chart checked, practitioners reminded of importance of checking care plans, training and supervised practice provided to the clinician directly involved. Patient confirmed as unharmed by in person visit and assessment from B7 CNL.	Care plans to be checked carefully prior to visits.	Closed

GHC64805	29/01/2024	16/01/2024	19:33	Wotton Lawn Hospital	Wotton Lawn-Kingsholm Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Prescribing	Lorazepam	Yes	1mg		Oral		Following transfer from rehab unit and patient's arrival on Kingsholm Ward on 16th January, the evening duty doctor (CT) prescribed PRN lorazepam as rapid tranquilisation. Instead of 1-2mg (one to TWO milligrams) up to four times daily, this was prescribed as 1-22mg (one to TWENTY-TWO milligrams) up to four times daily.	The error was subsequently noted by a Second Opinion Doctor, who reviewed the patient's drug chart on 24th January. The ward pharmacist was informed and the error was corrected by the ward FY1 doctor, who amended the prescription to 1-2mg lorazepam up to four times daily. At no point during the period between the original error being made and its subsequent correction did the patient receive more than 1-2mg of lorazepam up to four times daily.	SOAD reported to CQC, medications changed on EPMA, discussed with pharmacy and errors with electronic prescribing highlighted as a concern. Medics and nursing staff will double check all prescriptions	To double check when prescribing medications and raise concerns about errors as soon as possible	Closed
GHC64840	30/01/2024	14/12/2023	09:00	CYPS Management & Admin	CAMHS - Admin	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Ordering, collection or delivery	Guanfacine	No					X2 prescriptions issued 14/12/24 by Consultant, emailed and posted 1st class signed for to Market St Pharmacy, 9-11 Market St, Cinderford GL14 2RT The letter was not signed for by the pharmacy Email from Pharmacy 22/12 to say not received in post, ?delay due to Xmas post. Pharmacy happy to leave until new year. Email received 9/1 to say original scripts still not received and requested replacement scripts issued. Replacement scripts issued by same Consultant,emailed/posted 1st class signed for 9/1/24 - these were received 10/1/24	As above	further request for e prescribing	Once mail has left our site it is outside of our control. E prescribing would offer greater reassurance	Closed
GHC64855	30/01/2024	30/01/2024	10:30	ICT	ICT Forest North DN	Pharmacy-community	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Medication breakages / spoilage	Pharmacy	Oxycodone	No					Routine visit to replenish syringe driver - New stock of oxycodone in property collected from pharmacy by patients partner - During stock check i noticed one box was slightly damaged. On checking the medication one ampoule was damaged, causing liquid to spill from ampoule. Colour of medication also appeared off colour (slightly yellow)	- Stock check amended - Photograph taken - Ampoule and liquid discarded off correctly - Patient and partner informed regarding damaged ampoule - Datix completed	- On checking in medication that had been collected from the pharmacy for the syringe driver, the nurse noted a damaged box and on checking one of the vials had broken and leaked in the box - The nurse did everything necessary and safely disposed of the broken vial and documented it - No harm done to patient	Thank you for your datix, all necessary actions taken upon identifying the issue	Closed
GHC64857	30/01/2024	30/01/2024	10:30	ICT	ICT Chelt Town Centre DN	Care agencies (home care)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Methotrexate	No					visited to administer Insulin and noticed that lock box which has Insulin and Pt's medication in was not locked. Medication is given by Care company not District Nurses. When checking the lock box I noticed 2 dossette box of medication in there and upon checking then noticed that in one box there was 4 lots of evening medication not given and from the current box Saturday night's was not given as well.	Made sure medication and Insulin were secure and box locked.	Advised visiting clinician to ensure medications and insulin are in separate lock boxes to avoid confusion. Carers are aware they are to administer oral medications - this was arranged with care manager. Advised visiting clinician to discuss with care company.	N/A	Closed
GHC64876	31/01/2024	26/01/2024	14:15	ICT	ICT Cotswold South 2 DN	Pharmacy-community	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug has expired	Pharmacy	Hyoscine butylbromide	No					Checking in a new supply of medications for syringe driver, medication was collected from Boots this morning. One box of Buscopan was out of date.	Contacted Boots, who apologised and said they would replace the box if it was returned to them. Box marked as expired and recorded as 10 expired in stock level. Explained to patient what had happened and requested she return he box for replacement, she said she will do this when next set are collected. Checked stock levels and there was enough for several days	Good assessment and review of anticipatory medications All correct actions taken and escalated back to pharmacy and stock renewed	Timely review of anticipatory medications ensures there is no delay in treatment for patient	Closed
GHC64904	31/01/2024	26/01/2024	16:00	Eating Disorders	Eating Disorder Community	Pharmacy-provider	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Pharmacy	Phosphate	No					Two patients prescribed phosphate supplements in response to abnormal biochemistry. Calls received from both patients to advise, despite trying numerous pharmacies, no phosphate supplements are in stock.	Several calls made to pharmacies; advised that there is a national shortage and only the hospital is in a position to respond to scripts. Call to hospital pharmacy who advised that they can only accept scripts on white prescription pads, not FP10s which are available to our community prescribers. Call to SDEC (Same Day Emergency Care) who advised they are not able to issue these scripts. Call to Mental Health Liaison Team who advised they do not have access to these white scripts. Call to A&E who agreed to provide the white scripts for the phosphate supplement. Yesterday (30th January) a patient presented to the hospital pharmacy to collect a prescription and they were informed there are only 4 of these phosphate supplement tablets left in the hospital now, and they could not issue the script.	Ops lead and Clinical lead reviewed. National shortage of named medications below. At the time patients were able to secure medications but this was following extensive calls to various pharmacies who did not have the supply in stock. Escalated to lead pharmacist for a view.	Escalation to lead pharmacist. Meds are stocked but very limited to specific pharmacies. Prescribers and medics aware. Guidance on other options to be gained following review/liaison with lead pharmacist.	Closed
GHC64920	31/01/2024	31/01/2024	19:20	LD Inpatients - Berkeley House	LD Inpatients - Berkeley House	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Ordering, collection or delivery	Propranolol	Yes	10mg	20mg	Oral	Oral	During medication found to have shortage of prescribed medication.	Administered medication available and further stock ordered.	Medication ordering regime updated and reviewed	Medication ordering regime updated and reviewed	Closed
GHC64938	01/02/2024	31/01/2024	20:27	PICU	Wotton Lawn-Greyfriars PICU	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administered with known allergy	Administration	Haloperidol	Yes	5mg		Oral		Patient elevating with psychotic features driving assaults towards staff and attempted assaults towards other patients. Patient was also distressed and demonstrated disruptive and chaotic behaviours. Due to this patient was put on a 5 (2) as they were informal and prescribed and given RT Haloperidol. It has now been noted that patient has an intolerance to Haloperidol (Akathisia) which is flagged as an allergy on RiO.	Duty doctor contacted and Haloperidol discontinued. RT observations carried out at time of administration. To gather physical observations and ECG from patient when she is settled.	I have emailed the ward manager and consultant. The patient was too unwell to understand details of the error but have been informed by ward manager that her next of kin (Mother was). No adverse effects documented in notes following RT.	To ensure that notes are read carefully for allergies before administering any medication including RT. To inform patient or next of kin (if patient too unwell to understand) of any errors as part of duty of candour.	Closed
GHC64946	01/02/2024	01/02/2024	09:00	Charlton Lane Hospital	Charlton Lane-Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Medication storage issue	Storage	Doxycycline	No					Bag of medication dispensed at GRH found in patient's room (recently transferred to GRH and since returned to CLH)	Medication removed Reported to NIC Does not appear to have been opened	Managed appropriately	NA	Closed
										Medication storage issue	Storage	Lorazepam	No									
										Medication storage issue	Storage	Sodium valproate	No									
										Medication storage issue	Storage	Fluticasone + Umeclidinium bromide + Vilanterol	No									
										Medication storage issue	Storage	Nicotine	No									
GHC64968	01/02/2024	31/01/2024	08:00	ICT	Reablement Gloucester	Care agencies (home care)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Information / advice to patient not given / wrong	Monitoring / follow-up of medicine use	Not applicable	No					Patient had been given medication from an old dosette box.	Therapist called the care agency and advised them that the up to date medication was in the pharmacy bag .	Reviewed System 1 notes. Noted that therapist informed reablement district nurse and discharge summary was reviewed. It was noted that the new dossette was the same prescription as the previous dossette. Patient was sent home with a new bag of medication - however this was the same medication as prior to admission. Therefore no medication errors were made.	Medication training has now been provided to increase staff awareness and confidence.	Closed
GHC64972	01/02/2024	01/02/2024	16:30	Cirencester & Fairfrd Hospital	Ciren Hosp- Coln Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Medication storage issue	Storage	Morphine	Yes	2.5mg		Oral		Attended to patients room to lock away medication delivered from pharmacy. Patients relative handed me a bottle of Morphine Oral Solution that had been left on the patients bedside table.	Verbal apology given to the family Medication removed from room, no date of opening documented on bottle Datix Completed	ward manager has spoken to the staff member who made this error and discussed the importance of checking the area	staff member aware of their actions	Closed
GHC64979	02/02/2024	01/02/2024	06:00	District Nursing (ENDS)	ENDNS- Out of Hours DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Controlled stationary (medication related)	None (no harm caused by the incident)	Wrong time / frequency	Prescribing	Oxycodone	Yes	1.25 mgs		Subcutaneous		Visited to administer a stat dose for pain and agitation. The medication chart for drugs to be administered when required has no start date.	Rang the OOHs GP to get permission to administer the drugs necessary for symptom control.	S1 record reviewed. Patient has since passed away. Drug chart collected by family and the checking element does not occur. DN to address at next GP MDT meeting.	Thank you for your datix. To be discussed at Team time on 29/2.	Closed
GHC65011	02/02/2024	26/01/2024	11:30	ICT	ICT Glos Physio	Care agencies (home care)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Madopar (co-beneldopa, levodopa benserazide)	No					Discharge from d2a bed back home 2x meds not in dossette box and carers not giving to patient Medication Administration record chart not completed by care agency An old Medication Administration record chart in the property from likely D2A bed but carers not signing on this on their visits	Complete Datix Called Care agency to discuss They advised me to email them Email sent Line manager informed	All actions completed - referral also made to district nurse please see separate datix 65759 for more information	For brokerage top review with care agency - issue log being completed also	Closed
										Wrong time / frequency	Administration	Sertraline	No									
GHC65047	03/02/2024	03/02/2024	19:15	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Controlled stationary (medication related)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Other (unlisted)	No					Asked to administer GH injection presumed it was prefilled syringe but it was not. Not trained to administer injection . Nothing on notes to inform me it was a specific pen and you needed traininh	Called patients mother who normally gives injection, not happy to take advice over phone , not safe. Mother said not to give and I agreed. Said patient had previously missed dose. I have informed GP about missed dose. and apologised to mother and carers who were there that I cannot give.	Review of notes Downloaded documentation to review and read to add to notes Alert added to system RGN only to attend	Alerts not added caused delay in treatment to pt and stress to staff	Closed
GHC65059	04/02/2024	04/02/2024	09:15	LD Inpatients - Berkeley House	LD Inpatients - Berkeley House	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Drug administration omitted / delayed	Administration	Sodium valproate	No					Patient has epilepsy, medication unable to be administered as not available. Will attempt to administer once medication has been sourced. Missed epilepsy medication, increased risk of SUDEP.	Spoke to on call pharmacy and will be able to source medication. Unable to assess harm caused.	Monitoring of medication reviewed and updated process in line with pharmacy check	Staff need to check medication more concisely	Closed
GHC65091	05/02/2024	03/02/2024	08:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Aspirin	No					Patient reported that he had his medication early morning. Medication chart is not signed to indicate that he had his medications. Hand over medication chart not signed to indicate that medications were administered. Handover does not indicate that medications were administered. Late nurse asked Night nurse if she administered early medications and she confirmed that she had not. Patient had therefore not had early medications administered.	Reviewed Medication handover form Reviewed handover sheets of Night 2/2/2024 and Early 3/2/2024 Reviewed medications chart Spoke with night nurse to clarify administration of medications.	Reflective discussion with bank nurse Reflection completed by substantive nurse Changes implemented on handover sheet as prompt to ensure medication is given by night nurse.	No further lessons identified	Closed
										Drug administration omitted / delayed	Administration	Docusate	No									
										Drug administration omitted / delayed	Administration	Lansoprazole	No									
										Drug administration omitted / delayed	Administration	Linagliptin	No									
GHC65094	05/02/2024	02/02/2024	14:10	ICT	ICT Cotswold South 2 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Ondansetron	Yes	4mls	21.9mls	Subcutaneous	Subcutaneous	Arrived at patient's house to replenish syringe driver. On arrival patient informed me that the syringe driver had been beeping throughout the night most of the day. Syringe driver check carried out and identified that the syringe pump had not been delivering overnight. Patient not reporting any symptoms relating to the drugs in the driver	Syringe driver check carried out and syringe driver monitoring she completed. Line checked and clamp was very slightly closed, but not occluding the line completely. Butterfly insertion site checked, slightly pink. Decision made to replace the butterfly and the line, the new administration line does not have a clamp. Remaining contents disposed of in destruction pot, observed by the second member of staff present on the visit. Patient advised to call the district nurse helpline if the syringe driver alarms again, and explained that if it is alarming she may not be getting the medication that she needs. Patient confirmed she does have the number. Advised patient to ring if she has any symptoms and we can look at giving as required medication. New driver set up and running upon leaving.Syringe driver checked on	Good problem solving to ascertain cause of pump not delivering medication Re sited and replenished Ensured patient had contact details for DNs and to escalate if pump alarming	Good assessment of syringe driver and problem solving	Closed
GHC65133	05/02/2024	29/01/2024	14:00	ICT	ICT Chelt Peripheral DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong / unclear dose or strength	Administration	Oxycodone	Yes	10mg	5mg	Subcutaneous	Subcutaneous	On arrival to replenish patients syringe pump on 28/1/24, I noted that the range for oxycodone was prescribed as 2.5 - 5mg, however for the last 2 days, according to the drug prescription chart, the patient had 10mg oxycodone administered into his syringe pump. Patient was alert and awake during visit.	Current syringe was empty so removed and replenished with correct maximum dose of 5mg oxycodone in it. Patients daughter informed me that his GP was visiting the next day so TASK sent to GP to request that chart is re-written to increase range as his symptoms were not controlled on current doses.	- Reflective discussion held with 2 colleagues involved in incident and documented as significant discussion, and attached to personnel file. - Both colleagues will complete their own reflection of the incident, considering all contributing factors (for example any time constraints on that day, distractions within the property etc). I have asked that this be returned to me to review next week, this will also be added to p file. - Both colleagues will redo their syringe driver competency, being observed 3 times in practice by other competent Registered Nurse colleagues. Both are aware that if they are allocated a visit to replenish a syringe driver that they must ask for support to carry this out until competency is achieved. Management team (Nurse Lead and Community Manager have also been made aware). - Reassurance has been provided to both members of the team and ongoing support will be provided as required.	- Both colleagues identified that there were external distractions during the visit that need to be considered in future which may require them to find a quieter space to work to prevent the risk of future errors. - It was also identified that this patient was taking additional oral analgesia and therefore an increase in analgesia within the syringe driver may have been appropriate, however this needed to be reviewed by a prescriber and chart amended before increasing the medication.	Closed
GHC65146	06/02/2024	06/02/2024	08:30	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Stock balance recording errors / discrepancies	Insulin glargine	No					in pts property while performing daily insulin. Completed stock check as we do every Tuesday, noted that the stock chart has not completed since the 16th Jan but it stated that there were 13 insulin pens in the house. On my count today there was only 9 pens, with one in use. On the stock check the week before it stated there were also 13 pens. the pt uses 32 units a day, which is not enough to get through that amount of pens. pt states that he does not touch them, although his son will move them out the way if putting shopping away, had general look, but not to be obviously seen.	informed shift lead documented the correct number of insulin pens in the house completed datix	Appropriate action taken by visiting nurse to question stock levels. Appears documented incorrectly and there haven't been consistent stock checks of the medication. No further action required and no more incidents. Likely documentation error.	To keep on top of stock checks weekly.	Closed
GHC65160	06/02/2024	03/02/2024	19:45	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Senna	Yes	22.5mg	7.5mg	Oral		Patient prescribed senna 7.5mg once daily. Documented as administered at 15:00. Further 15mg administered at 19:45 under PGD.	Error noted 3 days later - no adverse effects documented Patient was already being regularly reviewed by medics due to concerns over constipation. To inform patient when available.	Nurse completed supervised drugs round, refection demonstrating learning and also completed elearning related to PGD	To raise ongoing issues with usability of EPMA system through management channels.	Closed
GHC65174	06/02/2024	03/02/2024	18:30	Wotton Lawn Hospital	Wotton Lawn-Kingsholm Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Preparation by administering clinician(s)	Pregabalin	Yes	100 mg		Oral		Patient was due for oral pregablin 100mg capsule tablet in the evening (between 18:00 -19:59 hours. Due dose was administered at 18:30 hours and tried to sign in the RiO , with the co-signature , it was not accepted by the system and then tried to sign with the Tac card, both the attempts were failed.	Informed to the shift incharge	* Investigation conducted (ongoing) as to the reasons for staff being unable to sign off medications on RIO system once given. * Staff involved interviewed and gave full account of their efforts to sign off medications. * Liaison with Clinical Systems Team to identify what issue had caused the system to decline efforts to sign off medications. * Details supplied to clinical systems - patient ID, names of staff involved, and TAC card details.	* Staff had not immediately submitted a DATIX following this issue, staff reminded that such medication issues warrant an incident report as a means of identifying causes through investigation. * Staff had been requested to complete reflective accounts, however through investigation it became apparent that the issue was with the system rather than a staff member practices, therefore reflective account not required.	Closed
GHC65195	07/02/2024	06/02/2024	20:45	Charlton Lane Hospital	Charlton Lane-Chestnut Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong formulation	Preparation by administering clinician(s)	Nitrofurantoin	Yes	50mg	100mg	Oral	Oral	Patient has been given 50mgs of Immediate release Nitrofurantoin instead of 100mgs Modified release.	Informed Doctor on Duty will correct the prescription, No harm done to a patient and not a problem.	Medics contacted and confirmed no health issue and prescription amended.	None	Closed
GHC65223	07/02/2024	07/02/2024	14:00	Learning & Development	Learning & Development	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Medication storage issue	Disposal	Adrenaline	No					Received an envelope through internal post, containing 3 x Aurum Pre-filled syringes of OOD Adrenaline 1:10,000 with no note to say who the sender was.	Reported to line manager and emailed Chief Pharmacist for advise regards disposal	Reported to line manager and emailed Chief Pharmacist for advise regards disposal. Disposed of in safe manner (expelled and disposed of into sharps bin). Tried to find out who had sent the drugs but no one was able to identify this.	Advised relevant managers that drugs should never be sent in the internal post for disposal or otherwise.	Closed
GHC65244	08/02/2024	07/02/2024	21:30	Wotton Lawn Hospital	Wotton Lawn-Dean Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Promethazine hydrochloride	Yes	150 mg in 24 hours	100mg in 24 hours	Oral		Patient had 150mg of promethazine in 24 hours and was prescribed a max dose of 100mg	Duty doctor informed Contingency plan made of contacting again if situation escalates Proactive distraction techniques used Patient informed of when to have next dose Doctor prescribed alternative	Incident reviewed with ward doctor No error occurred No further action required	Medications to be clearly prescribed and prescription charts to be checked thoroughly by nursing staff during all medication rounds	Closed
GHC65264	08/02/2024	06/02/2024	19:10	Crisis Resolution Home Treatmt	CRHT West Glos	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong patient	Administration	Diazepam	Yes	5mg		Oral	Oral	Home visit by CRHTT to community patient. Senior MH practitioner mistakenly gave 5mg Diazepam to a gentleman, which was intended for another patient.	The error was noticed immediately, information given by Senior MH practitioner as to the like effects of Diazepam given to patient and patient's wife. Reassurance given and advised to call CRHTT if any concerns.	Asked and have received a reflection from the clinician involved and have discussed incident with them also. Will discuss the 5 r's of medication administration with the team as a whole at the next team meeting.	Will be going over the 5 r's of medication administration with the team as a whole as a reminder of best practice to try and avoid these situations going forward.	Closed
GHC65287	08/02/2024	26/01/2024	10:00	ICT	ICT Glos Physio	Care agencies (home care)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Rivaroxaban	No					Home 1st initial therapy assessment following hospital discharge back home with reablement support through the brokerage. Therapists perform a medication risk assessment which highlighted significant concerns around patient's ability to manage medication on his own. Patient recently suffered with delirium which is still resolving Patient hadn't taken morning medication, was not aware of that and carer had left the property without checking or encouraging him to take his morning meds.	-TC to care agency to explain concerns -TC to NOK to raise our concerns -Emailed care agency our concerns in writing, advised MAR chart is required and carers to ensure patient has taken meds on their visits -Advised NOK and care agency re liaising with pharmacy/GP in order to organise a dossette box for patient asap -Booked therapy review for next week	All correct actions undertaken by therapist.	For brokerage to review with care agency. Issue log being kept	Closed
										Drug administration omitted / delayed	Administration	Sertraline	No									
GHC65299	08/02/2024	07/02/2024	14:40	ICT	ICT Cotswold North DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Stock balance recording errors / discrepancies	Oxycodone	Yes	17 mg		Subcutaneous		Stock sheet in patient folder for Midazolam stated 15 vials, however there are 5 vials in the home Stock sheet in patient folder for Oxycodone stated 14 vials, however there are 4 vials in the home.	shift lead informed datix completed family aware	thank you for reporting this incident Error noted immediately and corrected appropriately Stock sheet corrected	n/a	Closed

GHC65316	09/02/2024	09/02/2024	00:00	CYPS/PH Community Specialist	CYPS/PH-Children Complex Care	Pharmacy-community	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Pharmacy	Lactulose	Yes	2.5millilitres		NG/PEG/PEJ		Patient prescribed Lactulose solution for constipation. Pharmacy failed to label strength of solution. Cheltenham Pharmacy, Springbank Community Resource Centre, Cheltenham.		Reviewed with Lead pharmacist - Lactulose is only one strength and therefore it is fine to be dispensed without the strength on the label Thank you for reporting this - you have followed the correct process	Will be shared at next team meeting	Closed
GHC65326	09/02/2024	08/02/2024	08:15	ICT	ICT Cotswold South 2 DN	Nursing / residential home	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Missing medication	Ordering, collection or delivery	Mometasone	No					Went to review patient to see the impact of the new steroid cream that she had been prescribed. Whilst reviewing patient's skin, checked with the carers, in the bathroom, asking us to check the drug trolley but the steroid cream could not be found. It appears it has not yet been collected and has not been administered. GP prescribed the steroid cream on 26th January 2024. A note was left in communication book by an HCA on 2nd February 2024 to remind care staff that this had been ordered and needed to be picked up. Cream still not present on visit on 8th February 2024, so the patient has not been receiving the treatment she should have been.	Double checked on the system and the cream was definitely prescribed. Spoke to the care home nurse and asked her to prioritise collecting this cream so it can start being applied. Message also left in communication book to advise it needs to be collected and commenced. Further appointment arranged to review skin	Notes review - evidence of medication being ordered Care home collected cream and started as soon as it arrived	Communication book not used by care home Regular meeting with care home to continue to raise concerns	Closed
GHC65327	09/02/2024	09/02/2024	11:55	Montpellier Secure Inpatients	Montpellier Low Secure Unit	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Olanzapine	Yes	Partial, unable to ascertain	210mg	Intramuscular		While administering a patient's depot injection, the patient grabbed the syringe and pulled it away, causing much of the injection (difficult to ascertain precisely how much) to spill on the floor. After this the patient immediately left the clinic.	Unit Doctor informed, plan to contact pharmacy for recommendations.	Intervention to be added to care plan- provide patient with reassurance throughout and consider administering in prone position	None	Closed
GHC65343	09/02/2024	09/02/2024	14:50	Wotton Lawn Hospital	Wotton Lawn-Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Administration	Other (unlisted)	Yes	5ml (10mg)		Oral		Service user requested PRN Oramorph and was accidentally administered PRN Simple linctus (cough mixture).	Staff explained to the service user that they had administered the wrong medication. Staff apologised to the service user and asked how they were feeling.	Staff followed policy and procedure	ensure correct medication is given	Closed
GHC65373	10/02/2024	09/02/2024	09:37	Charlton Lane Hospital	Charlton Lane-Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Methotrexate	Yes	2.5mg	7.5mg	Oral	Oral	Patient prescribed 7.5mg Methotrexate tablets. These are due once a week, and pharmacy dispenses just 7.5mg each week for the patient (3.2.5mg tabs). Patient has been signed as having the prescribed 7.5mg, but only one tab is gone, meaning patient only had 2.5mg rather than the whole dose of 7.5mg	Pharmacist made aware, will discuss with their team Ward staff to inform ward manager	Managed appropriately	NA	Closed
GHC65398	11/02/2024	10/02/2024	20:50	Dilke Hospital	Dilke Hosp-Forest Ward	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Co-beneldopa	No					admission from ED - GRH no medication chart no medication patient has Parkinson's	bank nurse printed ED clinical assessment and a list of medications called OOHrs GP who was in the building, who came to the ward and prescribed on paper chart medication taken from stock	All necessary actions taken at time of incident Patient admitted without medications nurse telephoned Hospital who transferred the patient. Out of hours doctor called who then came to the ward and prescribed medications in order for medications to be administered in a timely manner. Medications taken from ward stock Advanced Nurse Practitioner reviewed and clerked patient and computerised drug chart prescribed. Patient delivery and care not affected	All necessary actions taken at time of incident	Closed
GHC65404	11/02/2024	11/02/2024	09:30	Psychiatric Liaison	MH Liaison Alcohol Inpatients	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Contra-indication in relation to drugs or conditions	Prescribing	Diazepam	No					On reviewing patients on CIWA/Detox I noted that LW had been started on an intermediate-level alcohol detox regime. - She was admitted on 5/2/24 (admission was not alcohol related). - I did not notice any mention of alcohol in the clinical documentation. - The Nursing Admission records the AUDIT C score as 0 (zero). - There was no prescribing of an initial 24 hours of CIWA assessing. - There's no withdrawal symptom assessments documented via flowsheets. - An intermediate-level detox regime was prescribed at 20:07 on 10/2/24 (5 days after admission). - I did not notice any documentation of the rationale for this prescription. - It appears she's been inappropriately prescribed an intermediate-level alcohol detox.	The above has been discussed with Binoy the nurse in charge of GRH Ward 9B. Binoy will get this reviewed (discontinued) at the earliest opportunity.	Feedback from GHFT received. No action described	None described.	Closed
GHC65488	13/02/2024	13/02/2024	15:29	Recovery	Recovery Gloucester	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Zuclopenthixol decanoate	Yes	unknown		Intramuscular		Zuclopenthixol decanoate appears to have been administered (signature to indicate this) without being prescribed (prescription was not signed) on the following dates: 24/10/23, 7/11/23, 21/11/23, 5/12/23, 19/12/23, 2/1/24, 17/1/24, 30/1/24	Completion of incident form	Alerted by lead pharmacist about the error. TM discussed with depot clinic bank nurse (administrator of depot not signed). Medication had been written up but psychiatrist had forgotten to sign this. Reminder made that signature is legally required before administration and checking when a card is rewritten or on new 6 month review section that entire prescribing is correct before administering and if not requesting medic to do so. No change made to medication and same dose as previous 6 months administration noted. Nurse in question extremely apologetic and reflective, noting he will double check going forwards and was unsure how he had missed the absent signature.	Reminder sent out to nurses regarding double checking medication cards are entirely written out, noting that medics might be distracted and leave incomplete in error. Support worker involved in depot clinic also asked to check ahead of clinics.	Closed
GHC65498	13/02/2024	13/02/2024	08:45	ICT	ICT Forest South DN	Pharmacy-community	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Ordering, collection or delivery	Semaglutide	Yes	17 units	18 units	Subcutaneous	Subcutaneous	Attended for routine visit for support with BG monitoring and insulin administration support Patient insulin dose is 18 units daily. Upon dialling up the pen only 17 units in pen Checked property for more insulin - none in property	Administered the 17 units and marked the chart appropriately Telephoned the pateint's surgery who informed me insulin had been requested a week ago Went to pharmacy to find medication had not been prepared - advised by a staff member there that it may have been due to "supply issue". Advised her I was unaware of any issues getting hold of Semglee insulin. Waited for the prescription to be ready and taken to patient as unable to tell me when next delivery would be made	28/02/2024 - Community Nursing Lead - Patient receiving daily DN visits for support with insulin administration - On 13/2/24, not enough insulin to administer full dose. - Notes reviewed and insulin was ordered on 6/2/24 but had not arrived at property. - Staff visiting the day before did not check adequate dose in property for next day.	- Reminder to staff to check insulin stock levels in home to ensure requests have been delivered. - Check every visit that enough provision for next visit and ensure pen taken out of fridge in preparation for this. - The above discussed at team time and sent out to all staff via email also	Closed
GHC65517	14/02/2024	14/02/2024	10:30	ICT	ICT Cotswold South 2 DN	Other organisation (please specify)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Prescribing	Midazolam	Yes	25milligrams	25 milligrams	Subcutaneous	Subcutaneous	JV to replenish syringe pump On checking drug chart noted that midazolam and morphine boxes circled as micrograms not milligrams	Check of stock - correct Check of charts to correspond with amounts of stock Check of label on pump syringe Call to palliative care (name removed) before re-writing chart that this was definitely incorrect and not an obscure prescribing dose. Confirmed that it should be milligrams not micrograms and likely transcribing error. Chart rewritten by myself (INMP) and old chart removed from home.	Reviewed notes and all correct actions taken Palliative care team made aware of prescribing error at time of incident No harm to patient	Highlighted multiple nurses missed incorrect prescribing Added to leadership meeting to discuss Medication update need for wider team - lunch and learn to be added to schedule later this year	Closed
										Wrong / unclear dose or strength	Prescribing	Morphine	Yes	22.5 milligrams	22.5 milligrams	Subcutaneous	Subcutaneous					
GHC65525	14/02/2024	13/02/2024	13:30	ICT	ICT Chelt Peripheral DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong time / frequency	Administration	Glycopyrronium bromide	Yes	200mcg		Subcutaneous		Prior to visit I noticed patient had a syringe driver with 1.2mg of Glycopyrronium in the syringe. The out of hours team had visited the patient and given a stat dose of Glycopyrronium, therefore exceeding the maximum dose in a 24 hour period.	Contacted the palliative care team for advice and confirm maximum dose in 24hours for Glycopyrronium was 1.2mg Palliative care nurse advised to reduced the Glyco in the driver and add a small dose of Midazolam as well into the driver. Line manager informed.	Discussion with member of staff and followed policy process for medication incident error. Staff member completed written reflection, attended teaching session re medicines management, completed all medicines management modules and had supervised visits to patients for medication administration. Further discussion with staff member and feedback and signed competencies received. staff member assessed as competent to continue visiting patients requiring EOL medication.	Thankyou for reporting. Highlights importance for staff to maintain competencies and training regarding medicines management regularly and to pay close attention to reading the medication chart. Highlighted the the importance for staff to remain vigilant and free from distractions when attending to patients requiring medications.	Closed
GHC65555	15/02/2024	14/02/2024	10:35	Sexual Health Service	Sexual Assault Referral SARC	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Medication breakages / spoilage	Ordering, collection or delivery	Hepatitis B vaccine	No					Medication order delivered to SARC. Accepted by CW, no clinician on site. Medication left in SARC office until 13.30 when SOE lead contacted by CW asking what is required to do as the CW and SARC manager who have been trained in accepting medication according to the SARC Medication storage and management SOP were not available. No clinician on site. Hep B was out of fridge for 3 hours at room temperature. No monitoring of room temperature available	Reported to SOE Lead at 13.30 Medication stored at the request of SOE lead who was in Gloucester. Directions given. Hep B to be labelled not for use and placed in bottom of medication fridge to be dealt with by SOE lead on 20th Feb when next in SARC. Information disseminated to all SOEs by SOE lead.	Training including competency assessment designed and implemented for Swindon office staff Ordering processes reviewed	Need for office staff at Swindon to understand what medications are stored at Swindon and the process of accepting and safe storage to ensure cold chain. This is as a back up for when the usual process of a GHC staff member attending to collect medication is not possible Appropriate medicine safety processes followed when cold chain interruption was noted	Closed
GHC65561	15/02/2024	26/01/2024	10:00	ICT	ICT Glos Physio	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Ordering, collection or delivery	Metformin	No					Home 1st initial therapy assessment completed. Care agency at present also. Therapist and Care coordinator looked through the Discharge letter from the hospital and patient's medication at home. We couldn't find the following medication in the property: metformin 500mg at 8am, metformin 1000mg at 6pm, calcipotriol application 8am. Also, patient unable to take meds independently from separate boxes	Care coordinator contacted the GP and pharmacist Physio emailed GP practice re organising dossette box Wife will visit pharmacy later today also to get the missing meds Physio to complete Datix	correct actions taken - issue rectified	GHFT to review	Closed
										Missing medication	Ordering, collection or delivery	Calcipotriol	No									
GHC65577	15/02/2024	14/02/2024	13:00	ICT	Reablement Cheltenham	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Ordering, collection or delivery	Bimatoprost	No					Patient discharged from Acute hospital without medication	Notified GP. Requested medication based on discharge summary and a review due to the missing dose	GP reviewed medication and new meds- prescribed / dispensed - patient was struggling on discharge - had further falls paramedic / rapid response input and liaison with people involved in care and support needs to help prevent hospital readmission	not having appropriate meds on discharge could have impacted on patients health and well being - this was quickly identified in the community and appropriate actions taken to rectify the situation	Closed
GHC65602	16/02/2024	15/02/2024	10:00	ICT	ICT Glos Asp & Stbridge DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Insulin isophane human	Yes	20 units		Subcutaneous		Planned visit for morning blood glucose check and insulin administration. On preparing insulin no more Humulin I insulin in current pen, checked fridge n no spares in fridge. Unable to administer Humulin I insulin as medication not available.	Apologised to patient as per duty of candour. Informed B6 referral centre nurse and gained advise. Other prescribed insulin administered. Phoned GP and urgent order of Humulin I insulin made. Phoned pharmacy to check in stock. Went to pharmacy and collected insulin. Returned to patient house around 13:30 to administer Humulin insulin.	Visiting nurse contacted GP and a prescription was generated and collected to enable timely administration of medication on the same day. Email sent to ALL Nursing staff to emphasise importance of completing weekly stock checks and for timely request of medication supplies to prevent stock not being in the home. Visiting nurse apologised for delay in medication administration under Duty of Candour. No adverse effect to patient noted.	Email sent to all nursing staff to remind to stock check medication and supplies required for Insulin administration on a weekly basis and to order stock in a timely manner.	Closed
GHC65607	16/02/2024	03/02/2024	15:00	Wotton Lawn Hospital	Wotton Lawn-ECT Suite	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Prescribing	Paracetamol	Yes	1 gram		Oral		one of patient underwent ECT as an out patient complained of headache and paracetamol 1gram orally given following her recovery. Notified to the duty doctor to enter in the medication administration chart. Unable to sign the paracetamol stat dose ,showing " Not Enabled For Administration "	Notified to the duty doctor	Policy followed	0	Closed
GHC65621	17/02/2024	03/01/2024	20:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Chlorhexidine + Sodium fluoride	No					During the January Missed Dose Audit, a missed dose was identified during the 8pm medication round.	The nurse has been contacted to request a reflection within 7 working days. Emails sent to ward manager and modern matron.	Nurse completed reflection demonstrating learning from incident.	No further lessons identified	Closed
GHC65622	17/02/2024	07/01/2024	22:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Lorazepam	No					During the Jan missed dose audit, a missed dose was identified during the 22:00 medication round.	The nurse has been contacted to complete a reflection within 7 working days. Emails sent to ward manager and modern matron.	Reflection completed demonstrating learning.	No further lessons identified	Closed
GHC65667	18/02/2024	17/02/2024	09:15	ICT	ICT Chelt Town Centre DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Other (unlisted)	Yes	24 units / unknown due to leakage	24 units	Subcutaneous	Subcutaneous	The visit was for insulin administration. Patient has two insulins in the mornings. Both needles/pen devices were primed before administration. The first insulin was administered with no issues. On removal of the second insulin pen device, it appeared not all the insulin had been administered and was stuck in the safety plastic section of the needle. The patient did have a 'puncture wound' to indicate some of the insulin had gone in, but it was unclear how much. Patient well in themselves and safety netting information provided.	I contacted the nurse lead and informed her of what happened, she advised we can't re-administer due to being unaware of how much has gone in. Also advised to provide safety netting information to patient and carers and we will contact the patient later that day to see how they are.	Patient monitored correctly in relation to potential under dosing of insulin. no harm caused. no adverse reaction/BGL spike.	n/a	Closed
GHC65712	19/02/2024	16/02/2024	12:00	Recovery Units	MH IP Rehab-Laurel	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / omitted patient information leaflet	Use / possession of over-the-counter (OTC) medicine	Zopiclone	No					Room search completed. 10 strips of 7.5mg Zopiclone were found. It would appear Patient had taken 17 tablets over a three day period. Patient informed staff she had brought them for £100.	Zopiclone removed Leave revoked Manager informed Doctor informed Physical observations completed	This is a new type of incident. Concerns have been acknowledged in the risk assessment and care plans. Patient attended A&E, bloods and ECG completed. Medication reviewed.	This is a new type of incident. Concerns acknowledged in the risk assessment.	Closed
GHC65715	19/02/2024	12/02/2024	15:00	Wotton Lawn Hospital	Wotton Lawn-Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Prescribing	Clonazepam	Yes	0.5mg	see above	Oral		05.02.24 - TTOs prescribed for patient for periods of overnight leave (2 days) correct to current prescription 08.02.24 - During ward round patient medication was changed - clonazepam prescription stopped. 12.02.24 - patient given previous TTOs for period of home leave - clonazepam included. Patient received medication during period of home leave which was no longer prescribed. CHRTT supplied more medication (following TTOs).	Future TTOs amended Patient titrated from clonazepam appropriately	clonazepam stopped and CHRTT requested more medics aware resolved	TTOs to be done in a timely manner	Closed
GHC65720	19/02/2024	19/02/2024	11:00	ICT	ICT Chelt St Paul's DN	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Other (unlisted)	No					Visit allocated to me for routine bladder irrigation. On completing pre-administration checked, I identified that all irrigation solutions had expired and therefore I was unable to administer	Escalated to NWL Urgent task sent to GP to order more in preparation for tomorrow's visit Ensured GP F2F visit to RV prescribed regime Informed regular staff member of this team who also previously visited the patient	- Appropriate management carried out - Correct steps completed prior to administration of bladder wash out - No evidence of the previous administration being from the same batch as previous nurse documented expire as 08/2025	- None all appropriate actions completed - Frequency of bladder wash outs was changed after this visit so therefore the patients care was not delayed	Closed
GHC65724	19/02/2024	19/01/2024	11:00	ICT	Reablement Cheltenham	Gloucestershire County Council	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Information / advice to patient not given / wrong	Monitoring / follow-up of medicine use	Bumetanide	No					Patient discharged home with a domiciliary care agency 4 x daily via Home First pathway. Occupational Therapist visited patient at 11:00 on 15/2/24 to carry out a Home First initial assessment. Observed discrepancies between medication documented in the carer agency folder in the patient's property, and medication documented on the discharge summary and dossette box. Unopened dossette box was located in a sealed bag dated 12/2/24 and unable to identify location of dossette box that was being administered from since discharge. Topical cream was prescribed but not listed in the care plan in folder. No Medication Administration Record found in care folder or elsewhere in property. Patient's daughter advised that patient had declined to take the medication from the carers in the morning. Daughter administered medication instead which patient agreed to take.	Occupational Therapist telephoned the care agency to discuss. The care agency advised that the Medication Administration Records are completed electronically and not stored in the property. Care agency advised that the topical cream is on the electronic Medication Administration Record. Care agency advised that the current dossette box is stored on the bathroom shelf. Occupational Therapist requested that the new dossette box in the kitchen is used as this will be the most up to date from hospital and includes medication changes made in hospital.	appropriate actions taken by therapist on identifying concerns re medication	learning was shared with independent provider by therapist identifying situation	Closed
										Information / advice to patient not given / wrong	Monitoring / follow-up of medicine use	Bisoprolol	No									
GHC65759	20/02/2024	14/02/2024	12:30	ICT	ICT Glos North South DN	Pharmacy-community	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong drug / medicine / item	Monitoring / follow-up of medicine use	Mirtazapine	Yes	15mg	15mg	Oral	Oral	Medication review requested by physio On arrival noted dosette box, two individual bottles and MAR charts from residential home where patient had spent time post hospital discharge. Patient and carers notes confirm that since arriving home medication was being dispensed from the dosette and one tablet at 2200 from one of the individual bottles. Mirtazipine had been stopped on 15/1/24 by Cheltenham GP and Sertraline prescribed as an alternative. The Mirtazipine was still in dosette box and being given by carers. Also noted that carers were administering medication that son was leaving out for patient. None of the medication being administered was on hospital discharge.	Contacted carers and advised not to administer any medications for rest of day until advice had been sought from pharmacist/GP. Called 2 x pharmacy and GP surgeries as patient still registered under Cheltenham GP from respite. Usual GP practice pharmacist arranged for dosette box to be delivered that day by pharmacy assistant. New dosette arrived but was incorrect for evening medication. Agreed with pharmacist for evening medication to be administered from individual bottles that patient already had in house. Pharmacy assistant and I sorted out weeks supply of medication, removed from property all other medications so no further admin errors, directive notes for carers left in house for restarting of medication and I emailed the care company. A new dosette with correct medication will be delivered next week following the pharmacist completing an investigation and I will complete a support visit on the afternoon of this day.	- S1 records reviewed. - Discussed with Nurse who reported incident. - Incident occurred due to pharmacy error not DCA. - Incident investigation has been handed over to pharmacy to investigate their end. - No safeguarding need.	- Lessons to be learnt following investigation via pharmacy and for them to follow up.	Closed
GHC65820	21/02/2024	19/02/2024	12:00	ICT	ICT Cotswold South 2 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug has expired	Administration	Other (unlisted)	Yes	1 10 x 10 cm sheet	n/a	Topical		Attended to dress leg ulceration. On reviewing notes has had two prior visits with no photos or measurements taken, and no care plans written. Dressed wound as per prior visit - after completed and tidying up noticed Aquacel Ag+ was expired, used on one wound only.	Spoken to patient and explained this was expired, so may not be as effective, but will still absorb exudate. Not redressed after discussion as it has been very painful to do today. Went through remainder of dressings and creams, Dermol shower wash and cream also expired along with some other loose dressings. All disposed of with patients permission.	- Care plans now in place. - Senior nurse has reviewed patient since incident occurred. GP has prescribed steroid cream. - DN follow up booked.	- All new patients should ideally seen RN and have care plans written as soon as possible. Learning to be shared with wider team to book RN review if RN has not seen patient. - Old dressings/patients own stock to be checked before use. - No harm caused to patient, good assessment by visiting nurse.	Closed
GHC65821	21/02/2024	18/02/2024	20:00	Recovery	Recovery Gloucester	Nursing / residential home	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong patient	Administration	Clozapine	Yes	400mg Clozapine		Oral		A member of staff from the patient's accommodation reports that the patient took another person's medication. It is reported that 111 was called who then dispatched an ambulance. "Obs" were reportedly "normal". The Paramedics reportedly contacted a doctor who reportedly agreed that the patient did not need hospital admission. The patient reportedly took the following medication: "Atorvastatin 20mg Clozapine 400mg (200mg more than JP usually takes) Hyosone 300micro Docusate Sodium 200mg (which JP takes anyway)" Report from Registered Manager of accommodation: "Support staff had his medication and one others medication with them and when they turned to get JP some water he picked up the packet and took	Care provider manager updated GHC care team that staff member involved had been tasked with repeating medication management training and would be observed in tasks around medication to assure competency before lone working.	Medic and care coordinator informed of incident and briefed by care provider manager about assurances around investigation and staff training for staff involved. GHC care team to escalate concerns should there be a quality assurance concern if repeated issues around medications management at accommodation.	N/A for GHC	Closed
GHC65824	21/02/2024	17/02/2024	07:35	Sexual Health Service	Sexual Health Integrated ISH	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Medication storage issue	Storage	Other (unlisted)	No					17/2/24 Electrical work carried out at Hope House with full power loss for over 11 hours. 18/2/24 Further testing with power loss for an hour. 2 Fridge temps breached both days: max 16.9/9.5 and 18.4/9.9 19/2/24 am: alarm cancelled, but high temp not identified on max/min readings. 21/2/24 am fridge (1) high reading identified, but not fridge (2). Data downloaded and issue identified. Specimen fridge, incubator and freezer also assumed to have been affected	21/2/24 Pharmacist quarantined stock while stability assessed with MI resource. Affected stock marked / some disposed of. Data analysis pending for any patients receiving drugs no longer suitable for use. 21/2/24 D/W estate manager re email communication prior, will plan work for additional power back up to prevent future events 22/4/24 Immform stock incident reported	Additional evidence for need of assured uninterrupted electrical supply to drug storage areas and equipment.	Effective communication between departments re electrical supply	Closed
GHC65830	21/02/2024	20/02/2024	20:15	District Nursing (ENDS)	ENDNS- Out of Hours DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Prescribing	Morphine	Yes	5mg	5mg	Subcutaneous	Subcutaneous	Family called in for a stat dose, on arrival medication chart hasnt been signed for the doses or any start date on the form. Chart had already been used by previous nurses.	Discussed with prescriber and she gave verbal instruction, followed up with an email ti enable stat dose to be given.	review of notes - identified missed opportunity to check medication chart that had been collected by family, drug then given by same nurse who did not check the chart	To discuss in team leaders and ensure that adequate time is given to staff to check and assess at each visit. Learning to be disseminated and shared with teams	Closed
GHC65842	22/02/2024	22/02/2024	10:30	ICT	ICT Glos Asp & Stbridge DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Preparation by administering clinician(s)	Flupentixol	No					Patient has a MARS chart in the property however the pharmacy sticker on the medication box did not state the route, frequency or dose to be administered of the medication therefore I am unable to administer the injection today. Medication is fortnightly and the MARS chart has been in use. Medication was issued with 5 vials in the box originally, there are now 2 vials left.	I have requested a drug chart to be written from the GP and informed B6 in referral centre.	Discussion held with Band 6 to clarify if error has occurred.GP was contacted to request the appropriate chart to be written for future use. Discussed held with staff members to reiterate and clarify correct use pf charts going forward.	To clarify if charts appropriate prior to administration of medication. MARS charts only to be utilised if all information on medication: Patients Identification details Medication route Medication amount Medication dosage timings.	Closed
GHC65901	23/02/2024	22/02/2024	18:07	ICT	ICT Chelt Town Centre DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Estradiol	Yes	10mcg	10mcg	Other	Other	Visited patient on the late shift for pessary administration. Care plan in place on system one stated 10mg Estradiol Pessary and staff had been documenting on system one '10mg'. The prescribed dose on the box and the drug chart is 10mcg.	-Created new care plan on system one with correct dose -Informed late shift lead -Datix completed	30/4/24 Reviewed S1 documentation and correct dose administer but written incorrectly. Staff to reflect on administration of medication and is also reiterated in team times across locality.	No further actions required after feedback/reflection form staff	Closed
GHC65944	24/02/2024	23/02/2024	21:27	District Nursing (ENDS)	ENDNS- Out of Hours DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Diazepam	No					Telephone contact with daughter who reported that patients diazepam was missing. She reports that 2 x nurses have visited and 2 x carers and she is the only other person who has had access to these in the home. They were left on the table next to patients bed but are now missing. Daughter assured me she has searched for them throughout the house.	Advised we would complete a datix to investigate the matter and that I would report to OOHGP. Advised to request another prescription through 111 as patient requires this medication at night. I informed OOHGP about this incident and they have the case requesting more medication but I suggested maybe supplying a smaller amount to cover patient until this has been investigated. Patient had 28 tablets supplied on 19th Februaury and these are the ones now missing.	Reviewed notes, spoke to senior community involved with the incident and GP. Advised to have locked boxes in the house for injectable palliative care medications so that the nurses knew which medications they were responsible for. Already doing joint visits due to challenging family dynamics. Noted Medication had been found by the family. Arranged Joint visit with senior community nurse to discuss concerns about medication going missing, advised that family purchase a locked box, community nursing provided a lock box until the ordered box was in place.	Safe guarding contacted as young children in the property with medications left in the reach of children.	Closed
GHC65948	24/02/2024	24/02/2024	09:30	ICT	ICT Forest North DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Insulin human	Yes	unknown	42units	Subcutaneous		1.Visit for blood glucose monitoring and insulin administration. 2. Administered Humulin I 42units as prescribed to patient's right arm. 3.Safety needle left insitu for 10seconds following administration of dose. On removal of needle insulin dribbled down patients arm, some insulin also still in safety needle.	1.Phoned shift lead B6 to inform and ask for advice. Advised to complete datix and keep safety needle. I had already disposed of the needle into the sharps bin before making the phone call as I didn't know this was required. 2. Patient also prescribed Tresiba, administered into left arm as prescribed, this was uneventful. 3. Spoke with nurse looking after patient and informed him what had happened and asked to monitor patient. 4. Documented on system one and datix completed.	S1 record reviewed. It is clear that the air shot will get trapped in the needle cover, that's ok, that's normal function and that it will likely be deposited on the skin when the needle retracts, this is normal device functioning and is not a cause for concern.	Thank you for your datix Please ensure when completing the air shot that the needlleis at 12 o'clock position.	Closed
GHC65962	24/02/2024	23/02/2024	20:00	Crisis Resolution Home Treatmt	CRHT Chelt & Tewks	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Monitoring / follow-up of medicine use	Lithium carbonate	No					Patient not home at time of visit. Could not dispense evening dose of medication. Returned to the property 3 times. Attempted phone contact. Husband couldn't locate patient either.		Staff made all attempts possible to administer medication With patient's mental health profile this would not be considered to b unexpected NFA	None	Closed
										Drug administration omitted / delayed	Monitoring / follow-up of medicine use	Lurasidone	No									

GHC66010	25/02/2024	25/02/2024	15:00	Rapid Response & EONS	Rapid Response	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Ceftriaxone	No					17 ceftriaxone IV recorded in the stock drug book 14 in cupboard that can be seen 3 missing	spoke to SC RRP who is involved with stock of medication- 3 could not be found LOCATION IS PULLMAN PLACE- STOCK DRUG ROOM MIDDLE FLOOR- unable to be specific in location (further down this datix)	Review of drug cupboards, drug bags and medicines management underway	Medicines management within RR to be reviewed by Matrons	Closed
GHC66045	26/02/2024	26/02/2024	08:30	Charlton Lane Hospital	Charlton Lane- Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong patient	Administration	Atorvastatin	Yes	40mg		Oral		Pt administered wrong medications	Medications identified Patient informed and apologised to Physical observations obtained - NEWS 0 Dr informed to review Nok informed of incident	Managed appropriately Ongoing review by nursing and medical staff shows no concern	NA	Closed
										Wrong patient	Administration	Allopurinol	Yes	300mg		Oral						
										Wrong patient	Administration	Finasteride	Yes	5mg		Oral						
										Wrong patient	Administration	Lansoprazole	Yes	30mg		Oral						
										Wrong patient	Administration	Sertraline	Yes	100mg		Oral						
GHC66065	26/02/2024	26/02/2024	12:30	Cirencester & Fairfrd Hospital	Ciren Hosp- Windrush Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Contra-indication in relation to drugs or conditions	Administration	Rivastigmine	No					Rivastigmine 3 old patches were found on his arm when the nurse was about to apply a new patch which was due at 12 Noon .	Doctor was informed and his family was informed of the incident, his observations were taken and NEWS 0 also QDS Observations prescribed. The new patch was removed and ECG was taken. He's been observed for any other symptoms.	Incident reviewed Significant learning identified, and reflections conducted with nursing staff. Transdermal patches should be linked with Care Plan TD Patch application record pop-up prompt when admin medication on SystmOne - complex to access to assess history	PLAN - training for all registered nurses to be delivered at ward level. PLAN - Paper Transdermal Patch record to be reinstated in Patient's bedside notes for additional security and as aide memoire PLAN - Patient's with Transdermal patches prescribed to be identified on Ward Safety Brief	Closed
GHC66095	27/02/2024	27/02/2024	12:30	ICT	ICT Glos Physio	Care agencies (home care)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong time / frequency	Administration	Co-careldopa	Yes	Not known	12.5/50 x 4 per day, 25/100 x 4 per day	Oral		Physio assessment at patient's home. Noted dosette prescription medication not correct and all today's medication not present in box and Monday some still in box, tomorrow some not in box. Medication is issued by carers attending property. Discussion with family member that patient's Parkinson's symptoms worse today - this was also confirmed by discussing with previous physio who had visited last week.	Discussed with son - new dosette arriving tomorrow Phone call to care company to find out more information regarding carer report on issuing medication. Pictures taken of dosette box	All correct actions completed at time of event. Logged down on WPP issue log	To be reviewed in conjunction with other issues from WPP	Closed
										Wrong time / frequency	Administration	Amlodipine	Yes	not known	5mg 1xam	Oral						
										Wrong time / frequency	Administration	Co-beneldopa	Yes	not known	12.5mg/50 mg 1 per day am	Oral						
										Wrong time / frequency	Administration	Omeprazole	Yes	don't know	20mg x 1 per day	Oral						
										Wrong time / frequency	Administration	Sertraline	Yes	don't know	50mg x 1 per day	Oral						
										Wrong time / frequency	Administration	Simvastatin	Yes	don't know	20mg x1 at night	Oral						
GHC66098	27/02/2024	27/02/2024	17:00	ICT	ICT TWNS DN	GP	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong patient	Stock balance recording errors / discrepancies	Morphine	Yes	10mg	10mg	Subcutaneous	Subcutaneous	visit attended to replenish a syringe driver when completing stock check noticed Morphine ampoules were prescribed for another patient and have been used.	Contacted team manager and band 6 on duty for advice. Both advised to dispose of medication and complete datix. Disposed of medication in denature kit and documented on stock check sheets	Discussion with dispensing pharmacy. They confirmed that the patients meds remain in their CD cupboard and they were unsure of why this happened. Dispensing pharmacy would not hand me over to a manager or pharmacist to try and review why this might have happened, discussed with pharmacy lead for GHC who will follow up at ICB level.	Datix to be discussed at Team Time as patient was seen and drugs both stock checked and used by numerous members of nursing team. 6Cs of medication to be again re iterated	Closed
GHC66103	27/02/2024	27/02/2024	14:00	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Ordering, collection or delivery	Metformin	No					Patient admitted to hospital 09/02 & discharged 12/02 Medication sent home with patient Thiamine 100mg, 1TDS Patient has not taken any other prescribed medication, usually dispensed in dosette box (15 days) Current medication Meformin 500mg one BD Vitamin B strong compound tablets one daily Thiamine 100mg, 1 TDS	Phoned pharmacy to arrange delivery of medication Email to surgery for attention of GP	Review of notes Visiting nurse acted in timely way GP alerted and medication sorted appropriately as well as flagging missed medications	Diligence of nurse - good care and raised appropriately to GP	Closed
GHC66107	28/02/2024	28/02/2024	00:30	District Nursing (ENDS)	ENDNS- Out of Hours DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Controlled stationary (medication related)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Prescribing	Levomepromazine	Yes	6.25 mgs		Subcutaneous		Visited to give a stat dose for sickness. Patient has maximum dose of Cydizine in the syringe driver, has Levomepromazine in the home but is not prescribed on the medication as required chart. Rang Band 6 prescriber for a verbal message to administer Levomepromazine. When writing verbal message on the chart I noticed that none of the Medication as required drugs had a start date.	Spoke with Band 6 prescriber	Recognise when drug chart not completed with all prescribed medication	To always check when collecting drug chart that all is written up correctly	Closed
GHC66113	28/02/2024	28/02/2024	00:30	District Nursing (ENDS)	ENDNS- Out of Hours DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Controlled stationary (medication related)	None (no harm caused by the incident)	Wrong drug / medicine / item	Preparation by administering clinician(s)	Midazolam	Yes	2.5mg	2.5mg	Subcutaneous	Subcutaneous	Visited to administer stat dose of midazolam at 05.00. Previous dose given at 00.30 had the incorrect LOT number and expiry date documented on stock sheets and system one. The numnber documented was the numbers on the box of midazolam rather than the ampuole.	Datix completed following visit	Notes reviewed, staff member contacted and advice given on need for thorough and accurate checking of medication ampoules. Manager also informed.	Importance of thorough and vigilant attention when recording medication ampoules. Staff to be aware of not mixing different dispensed items into one package.	Closed
GHC66121	28/02/2024	28/02/2024	11:00	ICT	ICT Glos North South DN	Pharmacy- community	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Monitoring / follow-up of medicine use	Glycopyrronium bromide	No					Visit to stock check in Just in Case Medications. Glycopyrronium Bromide 200mcg/1ml out of date - 01/2024. Batch number and Expiry on the vials did not match the batch number and expiry on the medication box.	Out of date stock returned to pharmacy and new medication requested. Documented on S1. Datix completed.	- Referred to pharmacy to investigate. - See progress notes.	- No new lessons for GHC.	Closed
GHC66152	28/02/2024	28/02/2024	09:30	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Buprenorphine	Yes	20mcg/hr	10mcg/hr	Topical		Patient discharged from hospital in January. Referral received to continue with pain patch DN team continued with patient pain patch, applying same dose as prior to hospital admission. During todays (28.2.24) visit patient mentioned she had been receiving a high number of deliveries of pain patches - these were lower doses than the patch we were using. Informed patient i would look into why she is getting so many, and why the lower dosage patches with the surgery. After investigating case, found that pain patch dose had been reduced from 20mcg/hr to 10mcg/hr whilst patient had been in hospital.	GP notified Care plan amended New drug chart written	r/w of notes r/w of discharge summary Evident in summary that reduced dose of patch - not picked up by team, no notification form GP - communication breakdown Noted in GP records dose reduced - 20micrograms/hour stopped documented clearly	Reading attachments re discharge - NP assessments need the full time to be carried out not to be cut for capacity Changes not discussed with pt. potentially in hospital - however not able to confirm	Closed
GHC66162	28/02/2024	28/02/2024	16:30	Charlton Lane Hospital	Charlton Lane- Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Paracetamol	Yes	500mg		Oral		A male patient came back from home leave- He reported to staff nurse "my daughter gave me paracetamol at home". However, he was given medication by night staff at 07:07am.	-The daughter was contacted at 16:32 by staff nurse and daughter verbalized she gave her father 500 mg of paracetamol at 09:30 AM. -Duty doctor informed for urgent assessment -Physical observation done NEWS was zero -The night paracetamol to be omitted as advised by the duty doctor -Management team was informed -The daughter was advised regarding consequences of drug overdose	Managed appropriately	NA	Closed
GHC66183	29/02/2024	27/02/2024	15:00	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Midazolam	No					appointment for palliative support and leg care. Checking the JIC medication and chart I could not find the JIC medication. The medication had been checked in 7/2/24 and stock checked 14/2/24 by the visiting DN's.	Husband, daughter and I checked the house- cupboards and drawers and the box of dressings but the medication was not found. patient's husband said he had returned some old medication to Horton's pharmacy in the Market Place Cirencester around 2 weeks ago. telephone call to Horton's but they had no recollection that any JIC medication was returned. Hortons informed me the JIC medication was dispensed in a JIC box. I had left the property at this time. Telephone called made to [name removed] to ask him to look again, this time for a shoebox sized box. I returned to the house 28/2/24 to double check but the JIC box was not found. Email sent to the GP surgery to inform the medication has been mislaid, possibly returned to the pharmacy and to request a further prescription. The patient is not currently needing injections. I have no concerns that there is misuse of the medications.	Review of notes, discussed with staff. It is not felt that there is an suspicion of miss use. Genuine mistake. Very stressful time for the family, Husband very overwhelmed	To ensure that family are made aware of the medications and what their use is, how to store and what to take back to pharmacy	Closed
GHC66191	29/02/2024	29/02/2024	10:00	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Insulin glargine	Yes	34	34	Subcutaneous	Subcutaneous	In care home, was given medication box by staff. On insulin chart, noted that the visiting member of staff yesterday had put todays date instead of yesterdays date.	My laptop was not working so called KPF - said that there were no double visits for today and no entry for todays date.	Appropriate action taken by visiting nurse, showed vigilance and double checking of medication. No further action needed.	Vigilance shown by visiting staff member.	Closed
GHC66192	29/02/2024	28/02/2024	20:20	Cirencester & Fairfrd Hospital	Ciren Hosp- Coln Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Buprenorphine	Yes	10mcg/hr	Yes	Topical	Not applicable	x2 Bunov 10micrograms/hour transdermal patches found on patients back during assistance with personal care. x1 dated 20/02/24 x1 dated 27/02/24	Verbal apology given to patient on behalf of the ward. Bunov 10micrograms/hour transdermal patch dated 20/02/24 removed. Datix Completed	Good observations by ward staff- swift removal of patch. Ongoing issues with daily check- advised ward staff to ensure that they using the paper daily check sheets whilst the IT issue resolves. Apology given to patient in line with duty of candour.	ward manager in talks with IT to get the system one transdermal patch to pop up daily to ensure the nurses check daily as the current system there is no way the daily checks comply with the initial application check	Closed
GHC66194	29/02/2024	29/02/2024	11:45	ICT	ICT Chelt Peripheral DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Dalteparin	Yes	Unsure of amount, majority administered but some noted on stomach	5,000 units IU/0.2ml	Subcutaneous		Visited patient to administer Fragmin injection, aware patient suffers with dementia therefore carer stayed with me during the procedure. Carer identified patient as he was unable to confirm his date of birth, procedure explained. Carer offered patient reassurance and held their hands however when the needle went into the skin the patient became very agitated and flung both his arms up in the air. This caused the needle to come out of the skin, small amount of Fragmin noted on stomach, majority of medicine administered however unsure of exact amount.	Informed lead Contact made with GP surgery - GP informed of event & ask if they wish for any further Fragmin to be administered today as unsure exactly how much was given. Datix completed. Awaiting call back from on duty GP.	No action required, GP was informed and advice was given to the nurse.	Nurse followed the correct procedure following this incident	Closed
GHC66200	29/02/2024	29/02/2024	11:00	MH Specialist Services	Early Intervention Team GRiP	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Medication breakages / spoilage	Preparation by administering clinician(s)	Paliperidone	Yes	100mg		Intramuscular	Intramuscular	100mg Paliperidone depot (Batch: 126031) administered to patient. During administration syringe cracked and medication leaked/depot failed.	Incident happened towards the end of administration so majority of medication was administered to patient however, cannot be sure how much was administered. Excess/leaked medication cleaned up. All parts of the depot was safely boxed back up and has been taken to pharmacy. Pharmacist for team informed who has said they will return product to manufacturer and report a fault. Also reported to MHRA Yellow Card	Nothing further - pharmacy and MHRA identified no actions	None identified	Closed
GHC66203	29/02/2024	28/02/2024	15:00	ICT	ICT Stroud SevernHealth DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug has expired	Administration	Glyceryl trinitrate	Yes	4 x Sprays over 1 hour		Sublingual		DN visited patient for suprapubic catheter change who is prone to AD. Patient subsequently had an episode of AD following catheter change and Glyceryl Trinitrate spray was administered sublingually on 2 occasions (4x sprays in total). The spray was out of date, exp: 08/2023 however DN clinical decision was made to give it regardless due to the emergency situation to reduce risk of mortality at the time. The spray did work and patient recovered well after some time. GP was made aware.	Patient was made aware medication was out of date however accepted medication regardless. B6 + B7 were called to assist with visit due to long AD episode. Out of date medication was removed instantly from property and destroyed. Prescription was then complete for GTN spray and handed to patient and carer so they had it in further event immediately.	Situation discussed with patient and GP. Patient and his carer reminded of the vital importance of having in-date GTN available. Nursing staff reminded to check GTN prior to commencing treatment.	As above	Closed
GHC66216	29/02/2024	29/02/2024	15:00	ICT	ICT Chelt Peripheral DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Information / advice to patient not given / wrong	Monitoring / follow-up of medicine use	Oxycodone	No					When visiting a patient who is palliative, I noticed morphine sulfate was signed in on stock sheet, when this was not in the patient's property, oxynorm was	New stock sheet filled in with oxynorm and stock sheet for morphine sulfate was crossed through	Clinician involved provided with time to complete written reflection on incident as per above. Documentation powerpoint sent for refresher.	n/a	Closed
GHC66219	29/02/2024	29/02/2024	20:00	Charlton Lane Hospital	Charlton Lane- Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong patient	Administration	Olanzapine	Yes	7.5mg		Oral	Oral	During 20:00 nurse dispensed medication and put it on side of clinic. HCA running medications took medication from side; nurse did not clarify whom the medications were for however wrote a name of medication on the pot. HCA took medications to patient specified on the pot. HCA returned and Nurse clarified whom HCA had given medications to. On report it was apparent that the wrong name had been written on the pot and therefore the wrong patient had received the medications.	NEWS taken Duty of candour completed Duty Dr informed NIC took over medication round	Reflection completed by nurse demonstrating learning. Nurse recompleted competency HCA involved recompleted competency	No further lessons identified	Closed
										Wrong patient	Administration	Diazepam	Yes	3mg		Oral	Oral					
GHC66226	01/03/2024	01/03/2024	04:30	Wotton Lawn Hospital	Wotton Lawn- Dean Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Lorazepam	Yes	2mg		Intramuscular		Medication of IM Lorazepam due at midnight Patient is on regular IM Lorazepam every 6 hours Medication was not given at required time, hence missed dose Duty doctor contacted Advised to give due to possible risk of not administrating the medication Staff administered the medication at 4am	Duty doctor adjusted the prescription to correct the timings of the next dose	Importance of treatment plan for Catatonia re-iterated to staff All doses of prescribed Lorazepam must be given	Patient received dose later than intended following NIC liaison with Medics	Closed
GHC66235	01/03/2024	01/03/2024	09:38	Montpellier Secure Inpatients	Montpellier Low Secure Unit	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong time / frequency	Prescribing	Olanzapine embonate	Yes	300mg every week	300mg every two weeks	Intramuscular	Intramuscular	Correct olanzapine prescription is olanzapine 300mg depot every two weeks. It has been charted as every week. Olanzapine 300mg depot given on the 23rd February 2024 and the 1st March 2024.	Contacted pharmacy for advise, informed RC (Dr Ciobanasu), informed nursing staff, informed and apologised to patient, non-contact observations over the weekend, unescorted leave suspended, offer ECGs and physical observations to be taken.	Pharmacy advice sought and oral haloperidol dose was reduced.	None	Closed
GHC66250	01/03/2024	27/02/2024	14:29	Wotton Lawn Hospital	Wotton Lawn- Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Information / advice to patient not given / wrong	Monitoring / follow-up of medicine use	Codeine	Yes	30mg		Oral		Codeine shown as countersigned by nurse who did not countersign this medication.		IT/Clinical systems investigating this	awaiting feedback	Closed
GHC66258	01/03/2024	30/01/2024	11:30	ICT	ICT Chelt Town Centre DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Insulin glargine	Yes	26 units		Subcutaneous		I went to administer Insulin (Abasaglar) the pen in lock box didn't have enough Insulin, I got one from the lockbox in the fridge to realise that it was the wrong Insulin (Humulin 1) and after searching found none of the correct Insulin.	Checked notes on SystemOne, a task was sent on the 13/02/24 asking for 2 boxes of Abasaglar Insulin as Pt has only 1 pen left. I rang Pt's pharmacy to be told a box of 5 was dispensed on 14/02/24 and that it was still there with them. I called my Network Lead to inform them of the issue and was advised to also call and inform our Network Nursing Manager, which I did.	Team reviewed incident in team time. discussed usage of care plan for Tuesday checks and early intervention of daily medication orders. staff reminded best practise is to call surgery for medications.	n/a	Closed
GHC66303	03/03/2024	03/03/2024	01:15	Cirencester & Fairfrd Hospital	Ciren Hosp- Coln Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Controlled stationary (medication related)	None (no harm caused by the incident)	Missing controlled stationary	Controlled stationary							While checking weekly Patient's Own Controlled drug check, noted, particular patient account, page number 78, Injection Alfentanyl 5oomcgm 2 ampoules not found.	Datrix completed.	disregard datix	incorrect data	Closed
GHC66305	03/03/2024	03/03/2024	04:20	Cirencester & Fairfrd Hospital	Ciren Hosp- Coln Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Alfentanil	No					Earlier I completed the Datix regarding Injection Alfentanil Hydrochloride 500mcgm/ml -2 ampoules in page number 78 not found while doing the weekly checks. Later we found the balance in Patient's Own account is correct. Actually the patient admitted on 28/1/2024 and brought 2 ampoules of Injection alfentanil 500mcgm/ml and documented in page number 78. Patient readmitted on 29/2/2024 and brought 6 ampoules of Injection Alfentanil 500mcgm/ml and documented in page number 85. Patient on syringe drive with Injection Alfentanil. From the balance of 6, Staff used 2 ampoules on 29/2/24, 2 ampoules on 1/3/24, 2 ampoules on 2/3/24, then the balance would have been recorded as 0 for page number	Me and my colleagues were worried, we rechecked the book to check what went wrong.	incorrect data , medication located	staff did not check the other patinents own cd book	Closed
GHC66321	03/03/2024	03/03/2024	09:30	ICT	ICT TWNS DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Insulin glargine	Yes	unsure due to small amount of residue on stomach	38 units	Subcutaneous	Subcutaneous	Patient is on insulin OD - when retracting the insulin pen from the patients abdomen after administration - there was some residue of insulin on the patients stomach, it was a small droplet.	Informed the patient and reported to band 6 - ES [name removed] Follow up visit booked PM to check BGL.	Discussed with practitioner -Medication injected but removed from the skin too soon. -Safety needles in place -Small amount of medication left on the skin -Concern the patient has not had the full dose -Secondary visit completed to recheck BGL and within normal limits for the patient. - Discussion with practitioner about counting to 10 and keeping needle pressed into skin with auto shield needles. -no further concerns practitioner acted responsibly and escalated	Thank you for your honestly and completing this datix	Closed
GHC66322	03/03/2024	02/03/2024	16:00	ICT	ICT Cotswold South 1 DN	Self-care	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Oxycodone	No					Shortec- Oxycodone had been signed in on stock sheet at beginning of February. No longer in the home. Patients husband stated that he has likely taken it back to Hortons Pharmacy by mistake.	Datix to be completed to report missing medication. Emailed surgery to request dosette box for regular medication as patient feeling overwhelmed. Also requested more of the missing medication. Explained medications and their purposes to patient and her husband. Wrote for clarity on box DN use or oral.	appropriate action taken, datix completed and GP surgery contacted. There was no concern that the medication had been misused. The medication had most likely been returned to the chemist along with other medication in error, during a time of change and stress for the patient's husband.	Careful instructions to the family regarding use of, and safe storage of JIC medication may have prevented this scenario.	Closed

GHC66345	04/03/2024	02/03/2024	10:30	ICT	ICT Forest OT	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Telmisartan	Yes	20mg	40mg	Oral	Oral	RA SF contacted me to inform me he had noticed a medication error on patient GH medication MAR. The previous 4 days 27/02-02/03 patient had only been given half prescribed medication. Patient has 2 x 20mg telmisartan each morning but only 1 x 20mg tablet had been given.	RA SF reported the incident to myself who i then contacted 111 for medical advice and documented.	thank you for this appropriate datix appropriate action was taken at time of incident 111 advice was sought and datix undertaken this medication has since been discontinued by GP surgery	all reablement staff have medication training this month all of which staff will need to undertake competency sign offs for this incident has been addressed in one to one supervision with staff and line management	Closed
GHC66348	04/03/2024	02/03/2024	12:30	ICT	ICT Forest OT	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Colecalciferol	Yes	25mcg	50mcg	Oral	Oral	RA SF reported to myself that a medication had been omitted from the previous day 01/03. Only 1 x 25mcg stexerol D3 was given instead of the correct 2 x 25mcg stexerol.	RA SF reported the medication error to myself, i contacted the local pharmacist for advice on possible side affects from the incorrect dose given. They had no concerns and reported there would be no side affects.	thank you for this appropriate datix appropriate action taken at time of incident pharmacy advise was sought and datic completed	this event is scheduled for debrief and to be discussed on one to one with line manager medication training is planned this month for all reablement staff	Closed
GHC66373	04/03/2024	03/03/2024	22:07	PICU	Wotton Lawn-Greyfriars PICU	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Lorazepam	Yes	2mg		Oral		Additional 2mg lorazepam given to patient who had previously had 4mg in the day. Her current prescription states that she can have 4mg/24hrs.		As soon as this medication error was highlighted medical team aware, who completed relevant physical health checks. Nursing staff who performed medication error made aware of the error and produced a reflective piece to allow time for them to appraise the situation and reflected upon action that could be taken to ensure that incidents like this do not occur in the future. Patient not made aware of the medication error due to their current mental state.	To ensure that medication charts are checked thoroughly prior to administering medication.	Closed
GHC66394	05/03/2024	05/03/2024	03:15	Wotton Lawn Hospital	Wotton Lawn-Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong route	Administration	Lorazepam	Yes	1mg		Intramuscular		IM Lorazepam given as RT, administered in the deltoid muscle.		Ward manager sent an email to temp staffing manager (Cherie)- to advise and pass the message on to agency staff that we do not advise to give IM Lorazepam in the arm.	Email sent to Priory Ward team to remind that we do not give Lorazepam IMI in the arm Email sent to Cherie to cascade message of above to mitigate this from happening again.	Closed
GHC66433	05/03/2024	04/03/2024	20:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Prescribing	Cyclizine	Yes	50mgs		Oral		Both myself and a colleague accepted a verbal message for Cyclizine 50mgs, however to date the stat dose has not been added to the medication chart.	Reported situation to ward manager.	Discussed with ward consultant psychiatrist who discussed with medic involved. System error had prevented him prescribing which has now been rectified. As over 24hrs nursing staff unable to sign medication.	Feedback to medic that would be helpful to communicate it was system error and reflect that in documentation if occurs again. So more easily able to identify incident as system rather than user error.	Closed
GHC66466	06/03/2024	06/03/2024	12:00	ICT	ICT Forest North DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug has expired	Administration	Leuprorelin	Yes	11.25mg	11.25mg	Intramuscular	Intramuscular	I was asked to go and visit the patient to do a prostap injection. I had to pick up the chart at the surgery but was told medication with patient. On arrival, Neighbour gave me the injection and after doing it I noticed it was out of date.	Straight away I called his GP who told me that just the product will be less effective but we couldn't do another thing about it. After I apologised to everybody and told a band 7 back at the office.	S1 record reviewed. Nurse attended patient to administer medication. Nurse realised medication was out of date. Apology given to patient. GP contacted who advised that patient would come to no harm but medication would be potentially not as effective. Next appointment made for patient to be brought forward. Nurse reminded of the 6 rights of medication.	Datix raised at team time and all reminded of the 6 rights of medication. Nurse involved asked to complete the administration of medicines on care to learn.	Closed
GHC66550	08/03/2024	04/03/2024	20:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Olanzapine	No					20:00 medications were not signed for few patients on the ward by the staff on late shift. Staff on night shift couldn't give those medication as staff was unsure whether it was administered or not. It was handed over from the staff that only 2 patient's 20:00 medications were not administered + laxatives were omitted for patients with diarrhoea , however the 20:00 medication were not signed for other 5 patients.	Tried to contact the staff Omitted those medication to avoid medication overdose in case if it was administered after having discussion with another qualified staff	Nursing team managed incident appropriately Reflection received from agency staff regarding incident	Reflection highlighted some medication in 20:00-23:59 not given specific time which leaves ambiguity. Nursing staff to prompt medics to prescribe with specific times.	Closed
										Drug chart errors - not signed, recording, other	Administration	Metformin	No									
										Drug chart errors - not signed, recording, other	Administration	Olanzapine	No									
										Drug chart errors - not signed, recording, other	Administration	Pizotifen	No									
										Drug chart errors - not signed, recording, other	Administration	Senna	No									
										Drug chart errors - not signed, recording, other	Administration	[illegible]	No									

										Drug chart errors - not signed, recording, other	Administration	Lorazepam	No									
										Drug chart errors - not signed, recording, other	Administration	Mirtazapine	No									
GHC66563	08/03/2024	05/03/2024	15:45	Recovery Units	MH IP Rehab-Honeybourne	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Pharmacy	Clozapine	No					2 Compliance aids containing clozapine were handed to someone in pharmacy to have the dose of clozapine changed. These 2 compliance aids when I phoned up on the 8/3/24 were missing.	Found out 08/03/24 at 09:30am when we asked to have the 2 compliance aids back, the staff in pharmacy had no recollection of any medications being dropped off. Telephoned the person who dropped the compliance aids off to get it verified. They were definitely dropped off and handed to a female pharmacist. However, the person dropping them off didn't know if they handed them to a GRH staff member of the Mental Health pharmacist.	Discussion with OT and pharmacy staff Medication handed in to main GRH pharmacy by mistake	OT now aware	Closed
GHC66590	08/03/2024	06/03/2024	10:30	ICT	ICT Cotswold South 2 DN	Other NHS Trust (please specify)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Prescribing	Insulin glargine	No					Went to collect insulin chart from surgery. ON arrival no chart found, told GP may have taken it to home day before. Went to care home, chart found, but prescription was only half completed so unable to administer. Impacted on the rest of the days visits as delayed sorting it out	Returned to surgery to get new chart completed by diabetic nurse. Insulin given from new chart. Told referral centre about delay to appointments	Well identified that drug chart was incorrect prior to administration	DN to liaise with surgery regarding prescribing and charts Good review of chart prior to administration Good escalation to shift lead	Closed
GHC66614	10/03/2024	09/03/2024	21:45	Wotton Lawn Hospital	Wotton Lawn-Dean Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Medication storage issue	Disposal	Other (unlisted)	No					patient used call bell - o/a patient handed staff bag containing her TTOs that she found when unpacking her bags following home leave.	staff thanked her for handing them over.	Patient handed TTOs to staff following leave period, Nursing staff reminded to search patients belongings following periods of leave	N/A	Closed
GHC66653	11/03/2024	10/03/2024	10:00	Psychiatric Liaison	MH Liaison Alcohol Inpatients	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Missing medication	Prescribing	Diazepam	No					Patient had been commenced on 24 hours initial scoring of CIWA. After this had completed on the 6/3/24, an intermediate level detox was indicated however this was never started.	reviewed the patient and their symptoms of alcohol withdrawal, advised ward staff monitor for break through symptoms and to give diazepam if required and liaise with ALT if any further concerns.	Incident closed pending GHFT feedback.	Depending on GHFT investigation	Closed
GHC66655	11/03/2024	10/03/2024	09:30	Psychiatric Liaison	MH Liaison Alcohol Inpatients	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Missing medication	Prescribing	Diazepam	No					Patient was being monitored on the initial 24 hours CIWA, when this completed on the 7/3/24 a low level detox was indicated however, this was not commenced.	reviewed the patient, no current symptoms of alcohol withdrawal evident. Advised ward staff to monitor for breakthrough symptoms of withdrawal and to give PRN Diazepam as required and liaise with ALT if needed.	closed pending GHFT feedback	Dependant upon GHFT investigation	Closed
GHC66713	12/03/2024	11/03/2024	17:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Prescribing	Fidaxomicin	No					On return from GRH, a patient was not given a course of their antibiotics as it wasn't prescribed or handed over that this needed to be prescribed or given.	Following the incident, the Drs were informed whereby they checked the medical handover, prescribed the antibiotic the following day so that the morning dose of the 12/03 was able to be given.	Discussed with nurses involved and aware for future to ensure that on return to ward a discharge summary is highlighted to medics including on call if out of hours to ensure medication prescribed promptly.	No further lessons identified	Closed
GHC66714	12/03/2024	08/02/2024	10:20	SALT Adults Physical Health	SALT Adults Physical Health	Pharmacy-community	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Pharmacy	Other (unlisted)	No					Patient recommended thickener in all drinks by Speech and Language Therapist. Letter requesting prescription for thickener sent to GP on 19th February 2024. Letter received by GP and prescription completed and sent to pharmacy (date unknown). Staff at patient's care home report the pharmacy have not completed prescription order stating 'it is on our list' after repeated chasing since before 5th March 2024 by care home staff. Pharmacy aware patient has run out of thickener. - The patient has run out of thickener and is at high risk of aspiration and associated consequences due to swallowing difficulties and frailty and reduced mobility. - Speech and Language Therapist unable to complete assessment without thickener and patient remains at increased risk of aspiration on regular fluids.	Speech and Language Therapist advised care home staff member to escalate incident to their manager and consider seeking alternative pharmacy to complete order and mark as urgent. Staff member at care home reported they will visit the pharmacy in person today and ask for order to be made today.	Request made to Speech and Language Therapist to check that care home had received the requested prescription of thickener. Care home advised that they finally received it on 15th March 2023.	Awareness that there may be significant delay to prescription requests. To ensure that safe swallowing strategies and suggestions for naturally thick fluids are made as appropriate as an interim measure. To request that care homes follow up prescription requests in a timely manner to minimise delays. Information to be shared at the next community team meeting and clinical governance meeting.	Closed
GHC66796	13/03/2024	13/03/2024	11:00	ICT	ICT Glos Asp & Stbridge DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Levomepromazine	No					Stock sheets show that there should have been 4 Levomepromazine ampoules left. Family had collected a new prescription today, which consisted of 1 pack = 10 ampoules. so there should have been a total of 14 ampoules but there was only 10. Checked with family they did not have the medications anywhere else in the home. Only 10 ampoules recorded today on stock sheets	Looked for ampoules and checked with family. only found empty box.	No action required - family contacted District Nurse Team to advise that medication was found in recycling bin post visit. Therefore all medication was accounted for.	No lessons learnt. All documentation was checked and clarified.	Closed
GHC66836	14/03/2024	14/03/2024	10:15	ICT	Reablement Forest	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Paracetamol	Yes	3x 500mg tablets		Oral	Oral	Patient takes x2 paracetamol 4 times a day. Patient has been declining paracetamol from PM dose, only taking the 1 other tablet so doses are unsealed. When administering patients AM dose I think 1 extra paracetamol was taken as patient picked a tablet up from the duvet and I gave morning tablets before realising so patient had 3 paracetamols instead of 2. I double checked dossette and 1 paracetamol was missing from Weds PM dose.	Informed the patient and phoned GP straight away. Spoke to the receptionist who when and spoke to a DR for me. She advised me the DR said it's fine and nothing to worry about but when patient has her next dose of paracetamol, to only take 1. I have recorded all this in the notes. I also informed the occupational therapist, my co-coordinator and senior.	SRA informed OT of incident as OT arrived during morning call. OT reviewed dossette and notes and indicated patient has been frequently declining paracetomol. RA's are assisting to administer Atorvastatin during the evening, paracetomol enclose in same compartment is being declined however RA's have left this in the dossette. OT has disposed of 5x loose paracetomol within the dossett that have been previously declined by patient to avoid error occurring again. OT to contact GP to request paracetomol in individual boxes as PRN and remov doses from dossette to reduce risk. OT to inform daughter of error.	RCO to make staff aware that loose tablets should be taken out of dossett and disposed of correctly.	Closed
GHC66884	15/03/2024	23/02/2024	08:55	ICT	ICT Cotswold South 2 DN	GP	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Prescribing	Insulin glargine	Yes	12 units		Subcutaneous		DN sent TASK to GP via reception to request review of insulin Ongoing hypoglycaemia, DN requested review and reduction of insulin GP replied directly to staff member to request reduction of 4 units Staff member was on annual leave	Further TASKS sent for an update and reduction of insulin did not occur until 6/3/24 GP provides weekly visits to nursing home Direct TASKS being sent to individuals delayed treatment No hypoglycaemic events during this period	Task reviewed - GP surgery normally send to central box - likely human error No harm to patient noted	agreed with Team Lead for Surgery to add noted to patients on going appts when task is sent that needs community nurse follow up Will add to team time (planned for 21/06) to inform team	Closed
GHC66896	15/03/2024	09/01/2024	10:00	Stroud Hospital	Stroud Hosp-OPD	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug has expired	Preparation by administering clinician(s)	Bevacizumab	No					In preparation for the eye injection clinic, it was discovered that 5 of the medications in the fridge had gone out of date yesterday (14/3/24) Bevacizumab (Avastin) 5mg/0.2ml 1.25mg in 0.05mL dose > Batch 2RMCYE2312036 [x 5]	These were disposed of in the correct manner under the direction of a consultant and replacements were retrieved from GRH pharmacy, having been requested by the same consultant. The replacements were delivered to department and the running of the clinic and patients were unaffected.	MEDICATION HAD EXPIRY DATE OF 14.3.24 . As checking medication on 15.3.24 was discovered out of date and disposed of correctly .	Audit of stock done on 11.3.24 and medication ordered . Delivery of stock came on 13.3.24 when all stock should been checked again . 14.3.24 medication is usually moved after lunch in readiness for Friday Clinic into eye injecting room . Consultant will always double check dates and medication before using when this was found . Alot staff sickness and only minimal RN cover during this week .	Closed
GHC66909	15/03/2024	14/03/2024	11:35	Assertive Outreach	AOT Stroud & Cotswolds	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Paliperidone	No					I went to administer depot (150mg PALIPERIDONE, Pre-Filled Syringe) but syringe broke and medication spilled onto my gloved hands and the floor, withdrew needle and explained situation to patient. Patient appeared unable to accept that he had not received the injection, I explained that I had put in the needle but as soon as I saw the medication leaking out of the syringe I withdrew the needle.	I apologised to patient and explained what had happened. He did not believe me and so I was able to withdraw the syringe element of the depot (needle was sheathed and within the sharps bin) to show him that medication was still in the syringe.			Awaiting Review
GHC66932	16/03/2024	15/03/2024	13:10	Wotton Lawn Hospital	Wotton Lawn-Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Monitoring / follow-up of medicine use	Escitalopram	Yes	15mg		Oral		Tablets were found on the table of the patient's bedroom. The tablets were half dissolved as if the patient took it out of his mouth.	The staff spoke to the patient about this incident. Informed the patient about the new care plan in which the staff will ensure the patient has swallowed the tablets and stay with him for up to 10 minutes after medication administration.	observation care plan in place to monitor compliance with swallowing medication to be observed by staff	N/A	Closed
GHC66942	16/03/2024	16/03/2024	11:30	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong formulation	Prescribing	Insulin glargine	Yes	16		Subcutaneous		I went to see the patient to administer insulin. When I checked his insulin pen I noticed he has two BN lot numbers and they do not match. There was one printed on the pen that said 3F9092A exp 04/26 and the other was on the sticky label from his prescription which reads 72488 exp 04/26. On his written forms, most people have put the BN number from the prescription and not the one printed on the pen. I highlighted this to lead RN on duty and I was asked to datix as the numbers do not match.	To Datix and for the next person going in to photograph the BN numbers.	Email sent to surgery to request advice Review of notes Review of photos	Diligence shown by visiting team member	Closed
GHC66981	17/03/2024	15/03/2024	16:00	ICT	Reablement Gloucester	Care agencies (home care)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Codeine	No					The Homefirst team are currently supporting a gent who is receiving care from care agency helping hands. It was previously discussed with helping hands that patient is unable to manage his medication independently and were advised that they would have to support with this. I was informed on Friday that medication had been missed again.	Contacted helping hands to report medication had been missed.	Highlighted case as part of WPP spreadsheet review of incidences occurring.	Difficult to maintain communication links and provide a seamless service when care/reablement is being provided between 2 separate services. As a result, this case has been taken over by reablement to gain a clear assessment of patients abilities.	Closed
GHC66993	17/03/2024	17/03/2024	12:30	ICT	ICT Forest South DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Monitoring / follow-up of medicine use	Other (unlisted)	Yes	15,000 units	0	Subcutaneous		Arrived to see patient for daily INR readings and Fragmin injections. INR performed with a reading of 1.3 as per GP advice Fragmin to be given. Patient informed me she self administered a dose of fragmin 15,0000 Units yesterday evening as a nurse did not come. I informed patient that a nurse did come and had already administered the fragmin. patient said she forgot a nurse had visited and already administered. Patient had written down on her calendar that a nurse was visiting and had written under it Given it to myself. Fragmin located and 1 missing and empty syringe on the kitchen work top. Decision not to administer dose until OOH GP was informed. Patient was very apologetic and cannot remember the nurse visit.	-Clinical Observations - Updated Shift Lead - Medication Checked - OOH GP contacted - Clear writing left on patient calendar that a nurse has come today and not to give herself the fragmin - Note also left with the box of fragmins and chart not to give herself the fragmin as a nurse will do it. Patient to go to Practice nurse tomorrow for daily INR readings and fragmin. - Patients own GP practice informed.	20/03/2024 - Community Nursing Lead - Incident and notes reviewed - Level of harm amended as patient came to no harm despite medication error. - Patient being seen by DN's over weekend only due to abnormal INR requiring regular INR monitoring and fragmin administration. - Usually attends practice nurse for appointments. - Patient has diagnosis of dementia and self administered additional dose of fragmin. - Appropriate actions taken by identifying nurse including reassurance to patient and guidance sought from OOH GP. - Safety netting visit performed - Hand over given to usual GP surgery	Thank you for your report. - Level of harm amended as patient came to no harm despite medication error. - All appropriate actions taken by visiting nurse including escalation to OOH GP, safety netting advice and reassurance to patient. - If further DN intervention required may benefit from a "lock box" for fragmin injections	Closed
GHC67013	18/03/2024	22/02/2024	15:00	Crisis Resolution Home Treatmt	CRHT Cots & Vale	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Pharmacy	Citalopram	No					Patient prescribed 20mg Citalopram OM. CRHTT ordered 7 days. Pharmacy dispensed 14 20mg tablets, however, the box stated 7. Dispensing error		Pharmacy contacted. Excess medication returned to pharmacy. All appropriate action taken with staff checking medication ordered against prescription and noting the discrepancy.	No lessons learnt. All processes followed and relevant actins taken.	Closed
GHC67024	18/03/2024	18/03/2024	13:30	Dementia	Memory Management CDN	GP	Medication incidents	Medication incident not involving controlled drug(s)	Severe (permanent or long term harm caused)	Wrong / unclear dose or strength	Pharmacy	Memantine	Yes	100mg	10mg	Oral	Oral	Patient on Community Dementia Nurse caseload. Home visit booked for today. Noticed patient had passed away on the 13th March. Contacted the daughter to offer my condolences and inform her that I was aware of her mother sadly passing away. The daughter then informed me that her mother has deteriorated in the last few weeks. She had become increasingly drowsy and refused to eat and drink. When the Doctor came out to visit her mother he noticed that she had been receiving the incorrect dose of Memantine. She was supposed to take 10mg/1ml OD but the instructions given on the label on the box were 10ml OD. So she was was being administered 100mg of Memantine. Over 10x the recommended dose. The daughter informed me that she had been taking this dose of liquid Memantine for the last few week/ one month.	The daughter reported to me that she asked the GP if she needed to take any further action, when the incorrect dose was noted. He said she did not and advised to change the dose back to 1ml.	Information received has been fed back to the ICB who are investigating if the practice raised a datix for this incident. Lead Pharmacist advised of the issues found who is investigating further if this is a prescribing issue at the practice or a dispensing issue at the pharmacy.	When the preparation of medication is changed to check earlier with the pharmacy and/or family the dosage detailed on the preparation especially if it's in liquid form and take corrective measures when clinically indicated.	Closed
GHC67073	19/03/2024	05/03/2024	11:00	Recovery	Recovery Gloucester	GP	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Ordering, collection or delivery	Flupentixol decanoate	Yes	120mg	260mg	Intramuscular		I was informed by L.C under the Recovery Team that he attended for his Depot of 26omg Flupentixol at GP. He was told they didn't have the correct amount and that he would need to return on 8th March. He was also informed that on his last visit he wasn't given the correct amount. He was told by the nurse that he only received 120mg not 260mg. Apologies were given. This did cause concern for MR.L.C Did present as fine but shared that although he had no negative or suicidal thoughts he didn't feel right feeling fuzzy just not right. Concerned about not having correct amount and his mental health deteriorating.	To return on Friday 8th March for correct amount Reported to his Locum Consultant Psychiatrist at Pullman Place Permission given from MR.L.C to have look at medical notes. No date shown in February	Ongoing project looking at depot transfer to primary care and how to support this more systematically.	Issue raised concerns correct prescribing and administration and timely ordering or supply (Aspen have a pharmacy), issue identified and awareness of by GP. Record of issue noted in terms of broader issues with depot prescribing and administration in primary care.	Closed
GHC67086	19/03/2024	09/02/2024	13:00	Recovery	Recovery Gloucester	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Preparation by administering clinician(s)	Lorazepam	No					When checking medication before taking this out, 14 x 1mg lorazepam were (1 strip) noted to be missing from one box (it was supposed to have 28 in it). Box returned to Pharmacy and they made up difference. This was part of 4 week supply regularly taken to patient under community team. CCO habitually checks all medications before taking these out due to patient (in the past) claiming not to have received all prescribed medications. There is also a history of patient over-medicating in past.	CCO communicated situation to Pharmacy who resolved issue.	Discussed with reporter usual medication management procedure with individual patient and continued advice to handover prescribing to GP (this has been a challenge due to patient's engagement with GP and local pharmacy and her difficulty with change due to ASC).	None identified at time, unclear of cause of medication being missing. Reporter maintained and believed that tablets missing on opening to check and that he does this due to patient's historic complaints about missing medications with overuse of medication.	Closed
GHC67089	19/03/2024	15/03/2024	13:30	Recovery	Recovery Gloucester	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Ordering, collection or delivery	Lorazepam	No					CCO habitually checks 4 weeks medication before taking this out to community patient. There is a history of patient over-medicating self as well as a history of her calling Recovery CCO (after medication has been taken out to her) to say she has not got all the medications she is prescribed in her monthly supply. 14x1mg lorazeam (1 strip) were missing from 1 box (that should have contained 28x1mg). There were also 20 tablets missing from the box of Quetiapine (36x300mg, when there should have been 56). Medications taken back to Pharmacy - they have held onto box containing 14x1mg lorazepam. They provided outstanding supply of Quetiapine.	Medication taken to Pharmacy. Manager emailed by Pharmacy. Medication taken to patient (apart from 1 box of 28x1mg Lorazepam)	Liaison with pharmacist regarding incident and recurrence from last month's supply and 2 separate medication having missing tablets Liaison with head of nursing for mental health and LD Liaison with lead nurse for West community Discussion with clinician (reporter) regarding usual checking of medication (he had not got to all boxes when spotting first missing medication and did not complete assuming there could not be further missing tablets in other boxes). SOP for medication management checked and vague on checking of medications, reporter had been advised in past he could check all, other CMHNs note not opening any. Agreement on nurse (reporter) checking with pharmacy medications onsite (not delivered to Pullman) for individual patient before taking to patient.	Review of SOP for medication management in Pullman was in progress by lead nurse for West and pharmacy and clarity on clearer processes around checking (only GHC pharmacy dispensed medications, factory sealed boxes not). It was clear there was some confusion around usual procedures across nurses and that reporter had perhaps been given advice previously around opening sealed boxes which was not in SOP. No clear cause for missing medication or evidence of negligence/malpractice found or noted. Clearer and tightened procedures around medication management noted needed and underway with communication across nurses in team.	Closed
GHC67121	20/03/2024	18/03/2024	08:51	Psychiatric Liaison	MH Liaison Acute Hospitals	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Haloperidol	Yes	1g		Intravenous		Haloperidol was prescribed both oral and IM (medication guidance was to administer IM if refused oral) however patient given both routes on the 18.3.24. and 19.3.24. Therefore received double the dose.	Discussion with ward doctor who will review patient and amend prescription to avoid another potential error	See datix progress notes. Reporter informed of outcome.	As summarised in GHFT feedback	Closed
GHC67122	20/03/2024	20/03/2024	14:00	Cirencester & Fairfrd Hospital	Ciren Hosp- Coln Ward	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Sodium chloride	No					Patient was admitted to Coln ward and I was handed over by the transport that in patient folder with medical notes was a bag of fluids to be hung up once she was here.	Looking in patient folder and a bag of sodium chloride 0.9% w/v 1000ml was in there, not in original package with line attached and primed with bung on the end. Patient was started on these iv fluids @ 11:15 on the 20/03/2024 to run over 8 hours- the patient arrived on coln at 14:00 and this bag was full with no evidence of it running at the start time it stated. Line was also a gravity flow not pump so again unsure if any of this had been started. IVI discarded and dr to assess and prescribe more as we are unable to use this one as we cannot 100% that nothing has been tampered with.	fluid bag had a bung on the end but was in a non medical bag, the presription chart was in the notes but according to this it was on free infusion and not a pump at 8 houry bag. the infusion was restarted using a pump with a new bag	poor handover and no fluid chart that staff could access to see how much had been infused. bad disgarded	Closed
GHC67139	20/03/2024	20/02/2024	10:00	ICT	ICT Chelt St Paul's DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Cyclizine	Yes	150mg	150mg	Subcutaneous	Subcutaneous	Discrepancy between stock sheet for cyclizine and number of ampules found today in the property by 5	Looked in all bags, patient unsure but did collect 15 more ampules yesterday but they were separate in a bag. Patient does not know where other 5 ampules ? admin error or misplaced	team and documentation not indicative of any substance misuse history. team to monitor medications ta each visit as per policy and escalate any further concerns to their team manager. Advised all team to ensure when stock checking to open all boxes when received from the pharmacy and recorded.	n/a	Closed
GHC67194	22/03/2024	22/03/2024	09:00	Long Term Conditions	Cardiac Rehabilitation Service	GP	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Prescribing	Clopidogrel	No					Reviewed patient in clinic following hospital admission 6 weeks ago. During assessment patient reported he had not been issued any of his new medication from the GP surgery and consequently had ran out of some medication, in particular Clopidogrel (for 7 days) and Bisoprolol (for 3 days). Explained the importance of these medication and my concern regarding not having Clopidogrel for 7 days. Patient felt well in clinic, had reported 2 episodes of chest discomfort needing to use GTN spray.	I contacted Cardiology Consultant via email, in doing this also contacted the secretary who informed me consultant likely on Annual leave today. I then contacted On-call Cardiac Registrar at GRH to ask for some advice, they advised this patient needed loading on Clopidogrel of 600mg today. Repeated this back to ensure information was accurate. Then contacted Duty Dr at GP surgery - explained the above, who kindly issued all new medication prescribed. Happy with loading dose of Clopidogrel and asked me to contact patient to inform. Contacted son (as requested) explained tablets would be ready this afternoon and when collected to ensure his dad has 600mg (8 tablets) of Clopidogrel this evening.	All actions taken by clinician to minimise risk - contacted cardiologist and liaised with GP.	To be shared with team at next team meeting.	Closed
GHC67202	22/03/2024	14/02/2024	14:00	Recovery	Recovery SC Forest	Nursing / residential home	Medication incidents	Controlled stationary (medication related)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong drug / medicine / item	Prescribing	Flupentixol decanoate	Yes	flupenthixol 200 mg IM	zuclopenthixol 200 mg IM	Intramuscular	Intramuscular	A patient has been taking Zuclopenthixol decanoate IM for decades. Patient has moved to a Nursing Home two months ago, on the 22 February 2024, I wrote to a GP to continue prescribing his injections and the GP replied on the 28 February agreeing with the prescription. This week, Our Community Pharmacist approached me asking why I have changed the patient medication to flupenthixol. I was puzzled.	I wrote the wrong name in my letter, it supposed to say zuclopenthixol but I wrote flupenthixol instead. I called the Nursing Home but it was too late, Staff has already injected the patient on the 14 March. I wrote to the GP to explain the mistake, I visited the patient in the Nursing Home, I explained to patient and staff my mistake. I reverted the prescription to the original zuclopenthixol. At the time of my visit, he was not reporting/ experiencing any changes and staff were able tot see any difference, mentally and physically.	The issue was discussed contemporaneously with doctor and it was raised with pharmacy. The patient / care home staff are aware of error. There has been no pattern of repeated similar acts and all candour processes were followed. There has been no harm.	Requirement to specifically double check medications in letters has been highlighted and emphasised with prescriber.	Closed
GHC67216	22/03/2024	22/03/2024	19:35	Charlton Lane Hospital	Charlton Lane-Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Lorazepam	Yes	3.5	2	Oral		Patient was prescribed 2mg Lorazepam in 24 hours(including IM, regular and PRN). Night staff noted that Regular 1mg was given on the 21/03/24 at 20:53. on the 22/03/2-24 patient was given 1mg RT at 07:23, 0.5mg at 13:16 and last dose at 19:35. This means that the patient had 1.5mg over the advised 2mg limit in 24 hours.	Patient is currently in the communal area being monitored by the night staff. Night Doctor made aware. NEWS: B/P: 105/59, SPo2:97%, Pulse: 82. Resp: 20 and Temp: 36.2 Day staff will be informed to inform family as DOC. Night staff informed patient as DOC and he did not understand the context of the conversation. Unable to identify the RMN that gave the 0.5mg as TAC card was used but no record of who used it.	Managed appropriately	NA	Closed
GHC67217	22/03/2024	22/03/2024	21:30	Wotton Lawn Hospital	Wotton Lawn-Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Paracetamol	Yes	1000		Oral		Patient was in pain . Requested for pain medications. During the hand over time staff administered pain medications, but has not signed for the medications. Patient requested for pain medications on night shift . Administered paracetamol at 22.15 again as not aware of the previous unsigned dose which was administered at 21.13.	Staff on late shift was informed and signed the medication later . Duty doctor was informed regarding the over dose of medication. NEWS 2 started. Scored 1 on NEWS 2 . Informed patient about the over dose .	ward manager spoke to staff in question and reinforced the importance of signing medication after giving this.	to sign medication after giving despite how disruptive the ward is.	Closed

GHC67220	23/03/2024	23/03/2024	03:00	CYPS/PH Community Specialist	CYPS/PH- Children Complex Care	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Contra-indication in relation to drugs or conditions	Administration	Tramadol	Yes	1.5		Unknown		I have drawn up the Tramadol medication, child has been awake for a while and Child's Mum wakes due to child being very upset and kicking and banging against the cot. Whilst Mum was administering puree feeds (due to me not being trained to give this) she flushed the extension set after and then gave child her Tramadol medication followed by water flush. Mum has given a medication which I have drawn up, Mum took over due to child being in pain and upset.	Complete Datix and medication administration as and when required with a note saying 'please look at health record'	No action to be taken - all correct policy followed	Shared at next team meeting to reinforce correct practice	Closed
GHC67229	23/03/2024	23/03/2024	10:15	ICT	ICT Cotswold South 2 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Pharmacy	Metformin	No					Whilst visiting patient, patient reported that had finished metformin yesterday evening, and had had no more supplied with normal medications delivered by pharmacy.	Phoned pharmacy, they stated they had missed putting up this medication. They stated they could do an urgent prescription to be collected today. I phoned referral nurse, patient unable to get medication, and had no one able to collect. Referral nurse stated I could collect medication in an emergency situation, this medication was needed. I contacted pharmacy and arrange to collect, and then took to patient.	Reviewed patient notes Incident occurred due to pharmacy error Good support for patient noted Medication collected as in patients best interest	Good escalation and reporting evident Good example of acting as support for patient	Closed
GHC67254	24/03/2024	23/03/2024	22:30	PICU	Wotton Lawn- Greyfriars PICU	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Controlled stationary (medication related)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong time / frequency	Administration	Lorazepam	Yes	3mg lorazepam	2mg lorazepam	Oral	Oral	Patient was approached by staff to have his regular medication and PRN. Patient took the medication and placed them in his pockets stating that he is not going to take medication. Patient reported that all the doctors are aware that he is not going to take any medication. Patient started to become verbally aggressive stating that his section is illegal and therefore he should be should be discharged. Patient stated that he does not have any mental health condition that requires medication. He kept on demanding that staff should call duty doctor, duty consultant and any managerial team who are on call to attend to him. Patient began to shout standing by the main front door. He refused to give them back to staff. Upon calling a PMVA team, staff offered him oral tablets 2mg lorazepam and his regular 10mg olanzapine. He took the 10mg olanzapine and gave them back to staff. He reported that there is no way he is taking olanzapine and took the 2mg lorazepam. He remained standing near the from door and visitors room and took the medication he had placed in his pockets. Staff did	Staff offered ton do his physical observations. He agreed to only have his heart rate checked. We continued with the non- contact physical observations. Duty doctor was called to be informed that patient had taken an overdose of 1mg lorazepam as he is prescribed between 1-2mg only.	Duty doctor informed and patients physical observations were monitored, to the best of the staff members' ability. This was difficult due to the patient not agreeing for physical health monitoring and therefore not-touch observations were completed, as per the RT physical health monitoring policy. Ward manager made aware of incident.	It is important not to give medication to a patient who has extra medication concealed in their pockets. Staff should first ensure the extra medication is removed from the patient before providing more, which would avoid a situation whereby a patient has the opportunity to take more medication than is prescribed.	Closed
GHC67312	25/03/2024	26/02/2024	11:30	MIiUs	MIiU- Vale Hosp	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Administration	Diazepam	Yes	4mg	60mg of codeine	Oral	Oral	patient given diazapam instead of codiene noticed this morning on checking of controlled drugs	patient was monitored anyway for 1 hour in department when given medication to monitor analgesic affect patient was discharged. Team lead informed.	Matron informed. Pharmacy Lead informed. Staff support given. Patient informed by Matron. EP to complete reflection.	Thank you for reporting. Staff supported. Patient fully informed.	Closed
GHC67316	25/03/2024	22/03/2024	16:45	Charlton Lane Hospital	Charlton Lane- Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Monitoring / follow-up of medicine use	Risperidone	Yes	1mg	0.5mg	Oral	Oral	Accidental prescription error, risperidone mis prescribed as 1mg OD instead of 0.5mg as patient was on discharge. 2 doses given of increased dose before highlighted by ward pharmacist. Consultant notified. Also to be noted that patient is on a covert medication plan.	Risperidone dose changed to correct dose, author to apologise to patient.	Medication changed as soon as error noted. Comment from consultant who will discuss with medic involved. "My comment is that we will reflect re incident in supervision"	No further lessons identified	Closed
GHC67323	25/03/2024	25/03/2024	09:43	PICU	Wotton Lawn- Greyfriars PICU	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Drug chart errors - not signed, recording, other	Administration	Haloperidol	Yes	5mg		Intramuscular		Patient distressed with perceptual disturbance and presenting with early warning signs with threats of violence. Oral RT offered and declined which was prescribed, however IM Haloperidol was flashing on system as requiring review. Medication administered before the IM form could be reviewed by medic.	Medics informed. Reflective practice.	Staff member had an opportunity to reflect on the incident and provided a reflective piece to the ward manager.	Always check a medication chart and if needed, get a second nurse to double check prior to administering.	Closed
GHC67329	25/03/2024	22/03/2024	15:00	Charlton Lane Hospital	Charlton Lane- Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Prescribing	Lansoprazole	Yes	30mg	30mg	Oral	Oral	Patient due to go on overnight leave on 22/03. Dossette box was not ready at time of leave, so agreed that nurse would drop the medication to patient's home address in the afternoon. When checking the medication that had arrived, it appeared as though the dossette box was incorrect. Paracetamol was missing (should be TDS) and the Lansoprazole dose was wrong (15mg in dossette when it should have been 30mg). It appears as though the medication was ordered on 20/3 and the Lansoprazole dose was increased on 21/3, with no new TTOs being ordered.	Patient informed that the dossette box was incorrect. She suggested that she would take the Lansoprazole from the next day to make up the correct dose and return the dossette to the ward on 23/03 for staff to send back to Pharmacy. Dossette boxes have now been sent back to Pharmacy for alteration.	Pharmacy dispensed dosette against initial TTO. Drs then updated TTO with additional meds but the orgininal had already been sent to the ward from pharmacy. Break down in communication from the ward to pharmacy re updates to TTO.	0	Closed
										Missing medication	Ordering, collection or delivery	Paracetamol	No									
GHC67356	26/03/2024	25/03/2024	08:10	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong method of preparation	Administration	Insulin lispro	No					Needle attached to insulin pen device and primed. 25 units of humalog mix 25 insulin dialled up and injected into subcutaneous tissue by pressing the button on the end of the device. Just before all the insulin had administered I noticed insulin leaking from the site. I did not wait 10 seconds due to leakage, but withdrew the needle. I do not know what dose of inulin was not delivered.	I apologised to the patient and advised a nurse would return later in the morning to check her blood glucose level. I contacted the shift lead in the referral centre to report the incident and arrange another visit.	Notes reviewed. No harm caused after event it would appear she did receive insulin. Appropriate action taken at time.	Offer staff training in safety pen needle devices. There is usually a small amount of fluid but shouldn't be significant. Continue to monitor.	Closed
GHC67366	26/03/2024	25/03/2024	08:30	ICT	ICT Stroud SevernHealth DN	Nursing / residential home	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Insulin human	No					Went to do a patients insulin in a care home and noticed that she had not had her insulin yesterday or did not even have an appointment.	Informed shift lead who rang care home and asked me to complete a Datix.	Will discuss with nurse who didn't book in appointment and will bring up in team time to remind staff to book in future appointments	Will discuss with nurse who didn't book in appointment and will bring up in team time to remind staff to book in future appointments	Closed
GHC67420	27/03/2024	21/03/2024	21:45	Charlton Lane Hospital	Charlton Lane- Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Lorazepam	Yes	0.5mg		Oral		Patient given 3rd dose of Lorazepam in one day (only prescribed PRN BD)	Noted at MDT on 27/03/24 - no side effects noted, Dr's review not necessary at this time	Managed appropriately No concerns with patient Nurse who administered to complete reflection	NA	Closed
GHC67442	28/03/2024	25/03/2024	11:45	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Preparation by administering clinician(s)	Insulin glargine	Yes	12 units		Subcutaneous		Patient on daily insulin Semglee 12 units to be given between 1700hrs and 1800hrs. Time of insulin was being bought forward. The prescription chart had not been signed and several doses had been given. I noticed this after I had given the medication.	Staff informed that I would go to the surgery to request a new prescription chart.	Review of S1 notes and paper notes in home. Three drug charts were in use, which would have led to the confusion. Old drug charts removed leaving one chart with the correct medication and dose. Drug was given correctly and documented just not in one drug chart.	Reminder to staff to remove old charts and paperwork to avoid confusion and prevent drug errors.	Closed
GHC67450	28/03/2024	20/03/2024	23:51	Wotton Lawn Hospital	Wotton Lawn- Abbey Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Monitoring / follow-up of medicine use	Promethazine hydrochloride	Yes	50mg		Oral		Patient was given 50mg Promethazine PRN upon request at 23:51. Patient had already had 100mg in 24 hours (max dose) so this exceeded the limit taking the patient to 150mg in 24 hours.	Patient informed as per duty of candour. Staff informed, staff completed reflection.	Patient informed as per duty of candour. Staff completed reflection.	Staff awareness of medication increased, this was discussed with management.	Closed
GHC67454	28/03/2024	15/03/2024	16:47	Complex Care at Home	Complex Care at Home Chelt	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administered when stopped	Administration	Dalteparin	Yes	10,000 units 8am, 7,500 units 6pm		Subcutaneous		On 4.3.34 Community Nurse unsure about when Dalteparin (Fragmin) injections were due to stop. Explained I was trying to plan introducing oral anticoagulant in advance to support patient with medication concordance. Patient has severe mental health diagnoses which required inpatient treatment just prior to acute physical health admission with Portal Vein Thrombosis. There are 2x discharge summaries as patient was readmitted following this initial diagnosis dated 15.2.24 & 20.2.24 which give 3x different dates as to when drug was commenced.	Spoke to Community Nurse on 15.3.24 as patient reporting GP advised to stop on 18.3.24 which didn't tally with 28 day treatment. Nurse spoke to a different GP who advised injections should have stopped a week earlier. I also spoke to Community Nurse Lead.	Action taken to ensure medication was stopped and communicated to all concerned.	Thankyou for reporting this incident. All concerned aware to check prescription in future	Closed
GHC67456	28/03/2024	21/03/2024	12:30	Wotton Lawn Hospital	Wotton Lawn- Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing controlled stationary	Controlled stationary							Patient own CD book lost - found to be missing during 3 monthly pharmacy CD balance check	Email sent to all ward staff by ward manager to look for book	CD Book found	n/a	Closed
GHC67470	28/03/2024	27/03/2024	13:00	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Other (unlisted)	Yes	48 units	48 units	Subcutaneous	Subcutaneous	Community staff nurse visited patient to take daily BGL and administer insulin. Identified that there was no more insulin in the patient's home contacted GP and asked for urgent prescription to be raised that day and for the insulin to be delivered to patient's home address in readiness for nurses to administer the next day as there would not be any insulin. Nurse asked Band 6 covering referral centre to follow up after 13.00. I contacted the surgery to see if the insulin prescription had been raised and was informed it had been sent to the patient's local chemist. I contacted Cohens Pharmacy in Tetbury and was advised that the insulin was out of stock and they had ordered it and would hopefully have it in a delivery the next day but this would be delivered anytime and even after midday. I said I would contact a member of the family to see if they could source the insulin from another pharmacy and asked for the prescription to be put back on the spine. Contacted the Son he said he was working until 22.00 hrs and could not help gave me his Aunty's phone number. Contacted patient's sister who said she	Contacted Family to see if they can obtain insulin, contacted Team Leader who advised to contact the DN for the caseload to let them know to follow this up. DN for caseload was able to obtain insulin and said they would take to patient's home address for nurse to administer the following day.	followed this up with team and several team members had ordered more insulin via email. Dispensary said they did not receive those requests. Patient now has a stock of insulin in her fridge. As a team we always order more insulin when we have one box of insulin pens left to ensure we always have stock. We should have checked with dispensary when no insulin had arrived to ensure they had received our requests.	Ensure patients have at least one box of full insulin in fridge if not and can see from notes it has been ordered then we must check with dispensary to ensure they have received the order.	Closed
GHC67493	29/03/2024	29/03/2024	09:00	ICT	ICT Glos North South DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug has expired	Administration	Insulin glargine	Yes	12 units		Subcutaneous		Planned visit for insulin administration. Patient has 2 insulins. 1 insulin that had been given for the past week has been out of date since December 2023. Only identified today, as chart can be confusing when the number 3 looks like number 5. On clear inspection today it appears that the date was 2023 and not 2025.	Out of date pen discarded, staff made aware that pen was out of date. Asked to discard any out of date pens. New pen taken out of the fridge for use today and in the future. Date checked.	This incident happened whilst patient was under the care of our trust. This incident was avoidable. The out of date pen was used for 1 week. No harm came to the patient. The pen was discarded and the care staff were asked to discard the remaining out of date pens. A new pen was removed from the fridge.	All medication checks must be completed thoroughly at each visit. This will be communicated to all staff.	Closed
GHC67570	31/03/2024	31/03/2024	12:00	Charlton Lane Hospital	Charlton Lane- Chestnut Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Information / advice to patient not given / wrong	Monitoring / follow-up of medicine use	Hyoscine hydrobromide	No					This Morning on everyday patch checking , Hyoscine hydrobromide patch 1mg/72hrs found missing from patient body. patient is non verbal, through gestures patient said she scratched it out and kept in the tissue paper and staff member unknowingly put the tissue paper in the bin in the communal area . 2 members HCA who given personal care this morning stated the patch was definitely there in patient body this morning	Informed to duty doctor who stated to reapply the patch today if salivation is excessive . The patch is every 3 days and is due tomorrow on 01/4 /2024	The medic was contacted and advised to replace patch if required.	None as the event was correctly handled.	Closed
GHC67573	31/03/2024	31/03/2024	08:50	North Cotswolds Hospital & GMC	NC Hosp- Cotswold View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Tramadol	Yes	200mg mr	100mg Immediate Release	Oral		100mg short release tramadol px in morning. Noticed on lunchtime round that had given MR not short release that morning. Also gave 2.	Nurse involved in the incident escalated to the nurse in charge and informed the patient immediately and apology given to patient. Nurse omitted the next dose of Tramadol due to prevent further increase of drug. Escalated to out of hours Doctor and blood tests taken to measure kidney function and liver function.	On review of this incident the correct procedure was followed once the error was identified. Patient was informed and prompt apology given. Actions taken to prevent occurrence were that drugs were removed from patient's pod and placed in patient own CD cupboard so that they were less likely to be used. Patient closely monitored for any adverse reaction to the overdose. Bloods stable.	This error is quite a significant error which was discovered 31/3/24. It is unsure how many times this error may have occurred during inpatient stay and therefore a group supervision session will be completed with all trained members of staff to review the incident and lessons learnt to prevent it from occurring again.	Closed
GHC67589	31/03/2024	31/03/2024	21:30	District Nursing (ENDS)	ENDNS- Out of Hours DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Drug chart errors - not signed, recording, other	Preparation by administering clinician(s)	Other (unlisted)	No					Patient was due for insulin administration this morning. Appointment was booked on S1 for insulin administration and woundcare. Insulin wasn't administered. Woundcare was done. No record of insulin administration on S1. Patient reported this to her carer around 20.30 and carer contacted OOH ENDNS.	Daughter contacted, she isn't with patient and doesn't know how to check BGL. Advised that a nurse would visit to assess patient. Nurse visited - BGL 14.9. Patient feeling well. Says that her insulin has been missed in the past and she has always been fine. Drug chart checked and no signature for todays (31/03) insulin. Insulin last administered at 10.20 on 30/03/2024. Nurse has contacted OOH GP but is awaiting to hear back from them. No insulin administered on this visit due to it being once daily and long acting. Has a visit booked for tomorrow morning for insulin and woundcare - checked on S1. Nurse advised patient to call OOH ENDNS if any concerns overnight.	18/6/24 Member of staff spoken to at time as new Bank HCA & advised to check care plans. Error occurred as was allocated to a bank RN initially then visit moved to HCA unable to administer Insulin to perform wound care so that RN could review complex wound. No harm to patient	18/6/24 Staff member aware to check S1 & Care plans and is awaiting Insulin training as well in future date	Closed
GHC67591	01/04/2024	31/03/2024	22:00	Charlton Lane Hospital	Charlton Lane- Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Medication storage issue	Disposal	Diazepam	No					Night shift staff noticed that medications for a patient was kept on the top of multiserv trolley in the kitchen. The medication was found to be mixed with aymes shake in a nose cup. Patients name was written in a disposable medication cup near by it.	The medication was discarded safely by the night shift RMN.	Staff advised of correct POPAM and all staff to be re-signed off	POPAM competencies revisited for all staff	Closed
GHC67597	01/04/2024	30/03/2024	22:00	Dilke Hospital	Dilke Hosp- Forest Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Insulin glargine	Yes	82 units	82 units	Subcutaneous	Subcutaneous	patient requiring insulin lantus 82 units at 2200, not enough insulin on ward so had to borrow from another patient(brand new in fridge and unused) mentioned to staff on Thursday re patient was likely to run out over the bank holiday weekend but none ordered	borrowed from fridge, other patients medication and order as emergency from pharmacy	As it was noted over bank holiday weekend, ANP issued FP10 and the required insulin was obtained by a porter from local chemist. 3 pens obtained therefore no need to order from Fairview pharmacy	NONE	Closed
GHC67617	01/04/2024	01/04/2024	19:20	Charlton Lane Hospital	Charlton Lane- Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Medication storage issue	Storage	Paracetamol	No					Patient was found to have blister pack paracetamol in her pocket. Staff are not aware how long she has had this medication. Patient then attempted to enter the clinic as the medication nurse was shutting the door, patient began pushing at the door and attempting to enter the clinic.	Staff took this medication off patient and searched their room to see if the patient had anymore medication. Patient made aware of the reason she cannot have medications on her person within the hospital environment. PBM techniques used to remove patient from the clinic into the female corridor due to the availability of medications and risks associated . Staff disengaged then patient was able to take herself to her room. Nurse informed not to administer paracetamol for a further four hours.	Incident managed appropriately by nursing team MDT aware and treatment plan reviewed PBM documented on separate Datix	None identified	Closed
GHC67652	02/04/2024	02/04/2024	08:45	ICT	ICT Chelt St Paul's DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug has expired	Preparation by administering clinician(s)	Other (unlisted)	Yes	16	16	Subcutaneous	Subcutaneous	On visiting patient this morning(2/4) it was noted that the insulin pen inuse had an expiry date of 3/2024. This pen had been used at previous days visit	New pen taken out of fridge and commenced. Patient given prescribed dose.	Next nurse visiting checked BGL and within normal range. No harm to patient, systemically well. Insulin pen disposed of and pens in fridge also checked and out of date ones disposed of. New insulin open commenced. Staff member who administered out of date insulin to be informed and medication error reflection to be completed. Patient to be informed of error at next visit by RN.	Staff to be reminded in team times to check medication information well at each visit including expiry dates.	Closed
GHC67688	03/04/2024	02/04/2024	08:30	Dilke Hospital	Dilke Hosp- Forest Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Prescribing	Fluoxetine	Yes	80 mgs	20mgs	Oral	Oral	Patient prescribed fluoxetine 20mg/5ml 20mls (80 MGS) to be given at 8am on system one. This dose given on 01/04/24. On 02/04/24 I went to give the dose prescribed on system one but noticed on the bottle it says 5mls to be given in the morning (20mgs). Dose not given and doctor tasked to review. dose changed to 20mgs.	Dose not given, Dr tasked to review, consequently dose changed	Patient prescribed Fluoxetine on drug chart - 20mg/5ml oral solution - administer 20ml Correct prescription on drug chart should have stated 20mg/5ml oral solution - administer 20mg Fluoxetine label on bottle states correct dose 20mg/5ml - administer 5ml. Ward doctor/ANP tasked and drug chart was amended to correct dose/quantity. Datix and error discussed with the medical team. Discussed datix with nurse who had administered the medication on the 01/04/2024. Nurse confirmed that she had checked the bottle of Fluoxetine at the time of administration correct dose clearly written on bottle. Nurse confirmed that she had only administered 20mg which was 5ml.	Discussion with medical team who prescribed the medication and also to the nurse who administered the initial dose. Colleagues aware of incident and were reminded to carefully check all processes from prescribing to administering medication going forward.	Closed
GHC67703	03/04/2024	03/04/2024	09:00	ICT	ICT Forest South DN	Pharmacy- community	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Amitriptyline	No					Attended patient home for support with insulin administration. Neighbour concerned that medication in dosette boxes are not the correct date. Checked all boxes in house and notes some were old so discarded. Checking the dosette boxes I noted that on the front the dosette boxes were correct for day of pick up but on prescription on the inside none of the dates had been changed from the previous month.	- Contacted son and he confirmed that the dosette boxes were correct as collected over the weekend. - Escalated to CNL N Meek who advised to speak to pharmacy - Discussed with pharmacy and technician asked for dosette boxes to be brought back in to recheck and correct dates.	08/04/2024 - Community Nursing Lead - Incident & notes reviewed - Patient has dosette box and carers prompt medications. - Noted that medication correct in new boxes but dates had not been amended on new boxes provided. - Contact made with pharmacy and arrangements made for this to be amended to prevent any ongoing confusion with meds.	All appropriate actions and escalation taken by community nursing team. Pharmacy to review their in house processes.	Closed
										Wrong time / frequency	Administration	Aspirin	No									
										Wrong time / frequency	Administration	Folic acid	No									
										Wrong time / frequency	Administration	Gabapentin	No									
										Wrong time / frequency	Administration	Lansoprazole	No									
										Wrong time / frequency	Administration	Lisinopril	No									
										Wrong time / frequency	Administration	Memantine	No									
										Wrong time / frequency	Administration	Metformin	No									
										Wrong time / frequency	Administration	Rosuvastatin	No									
										Wrong time / frequency	Administration	Sertraline	No									
GHC67705	03/04/2024	27/03/2024	11:00	ICT	ICT Stroud Cotswolds DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Adrenaline	No					Bank Bag 1 contains all the medical kit required for a nurse to do their job for that day. This also includes within the kit bag a Anaphylaxis kit which has gone missing for the 2nd time. First time happened in January 2024. Its a bright yellow pack containing the Adrenaline along with all the kit required if/when the need arises to use it. Admin Team always check the bag, ensuring the laptop and mobile phone are charged before the bag is needed for the shift. Medical Equipment is checked & serviced when needed. Adrenaline is still missing, and trying to locate. LOT No:0142664 Qty 10 Expire Date: Oct24	Immediate action: emailed 2 bank staff to highlight Adrenaline was missing, response from one is that she noticed it was missing but never mentioned anything and the other just grabs the bags and goes. Will speak to bank staff rather than via email to gather more detail on missing adrenaline. Changes to process: Nurse to check the bag before its taken, and sign they agree with what they are taking. Admin Team will also check the bag when its returned to ensure all kit back in bag.	Nil response to checking with staff if extra Adrenaline has been collected in error. All bank staff have been asked to check if they the stock as missing item has only been issued to them and no one could locate they still had it.	Suggest that bank staff are issued with adrenaline once demonstrated competence with training as all substantive staff do and that they remain responsible for that one box again as substantive staff do.	Closed
GHC67718	04/04/2024	03/04/2024	22:00	Dilke Hospital	Dilke Hosp- Forest Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Ordering, collection or delivery	Insulin glargine	Yes	82 units		Subcutaneous	Subcutaneous	patient due 82 units lantus at 22:00hrs, only 6 units available to use on ward. new pen for another patient in fridge had to be used so that dose not missed.	handed over earlier that morning by night staff that there was not enough supply left and asked to chase pharmacy. when attending for night shift tonight no supply. new pen for another patient in fridge had to be used so that dose not missed. emergency order emailed through to pharmacy overnight and to be followed up with phone call once pharmacy opens.	Insulin available from another patients supply therefore patient received insulin on time. Pharmacy contacted to ensure adequate supplies of patients insulin is sent due to high doses needing to be administrated. Added to safety brief to ensure staff check insulin supplies regularly.	N/A	Closed

GHC67723	04/04/2024	30/03/2024	20:00	Wotton Lawn Hospital	Wotton Lawn-Dean Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Macrogol 3350	No					One of the female patients in the Dean ward was due to take LAXIDO ORANGE oral powder sugar-free REG (Regular)1 sachet at 20:00 hours, and missed the dose.	None, as it was forgotten to be administered by the late shift staff.	Error identified during missed dose audit No harm to patient Staff asked to complete reflective account	Staff must code prescription chart for each medication	Closed
GHC67735	04/04/2024	22/02/2024	00:00	CLDT	CLDT Stroud	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Monitoring / follow-up of medicine use	Sodium valproate	No					Misread/misinterpreted information from MAR sheet. Added medication list to Rio. Follow-on planned appointment cancelled. Subsequently identified innaccuracy in medication list following re-arranged appointment.	Checked with GP/care provider. JUYI not available so unable to check medication info on JUYI. Discussed with community LD Nurse and plan for epilepsy protocol to be updated as information from Rio included in this. Checked information as above before sending clinic letter.	Staff Checked with GP/care provider. JUYI not available so unable to check medication info on JUYI. Discussed with community LD Nurse and plan for epilepsy protocol to be updated as information from Rio included in this. Checked information as above before sending clinic letter	Reminder to double check medication information when supporting care providers	Closed
GHC67750	04/04/2024	04/04/2024	10:45	ICT	ICT Glos North South DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Insulin glargine	Yes	37 units	32 units	Subcutaneous	Subcutaneous	Visited patient for daily BGL and insulin injection. BGL checked - 14.4mmol/l post breakfast. Prescription chart in home, having the IT issues before the visit didn't check care plan in SystmOne and misread chart - instead of 32 units given 37 units of insulin.	Informed and apologised to the patient, called B6 to inform about incident and discuss. Scheduled visit for afternoon to re-check BGL and tell patient to call 999 if they would feel worse. At the later visit rechecked BGLs.	-S1 records reviewed. - Agree with level of harm - no harm to patient. - Discussed with RGN who reported and error made from mis reading chart. - Error not occurred before. - Was unable to view records prior to visit due to laptop connection issues. - Newly qualified nurse just under gone all training. - Requested to complete a reflection. - 121 booked to discuss further and support with any other training and support needs.	- RGN aware to double check dose to ensure read and interpreted correctly. Never rely on previous entry on drug chart always check the prescription and dose prescribed. - RGN to ring for support if unable to access records and unsure.	Closed
GHC67786	05/04/2024	27/03/2024	13:00	ICT	ICT Chelt OT	GP	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Ordering, collection or delivery	Amitriptyline	No					Notified by patient and his wife on OT review visit today April 5th. March 27th Patients wife registered him at new GP surgery. Requested a repeat prescription of all her husbands medications , requested it was delivered in blister pack. Patients medications ran out April 1st Amitryptyline Atorvastatin Pregabalin renavit	Wife notified surgery receptionist requesting urgent delivery waited at house for following 2 days .As no delivery visited the pharmacy and was told they had not received the prescription from the GP (Church Street Surgery Tewks).	No further action needed as wife resolved the issue and medication received.	None.	Closed
GHC67794	05/04/2024	05/04/2024	08:20	ICT	ICT Cotswold North DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Insulin isophane human	No					Patient asked me to complete insulin administration today as patient was not feeling confident as just woke up. To get pen ready, i rolled the pen between my hands 20 times, then shook the pen side to side 10 times. Put the safety needle on. Primed the needle at 2 units, dispensed normal. I then drew up 6 units of humulin I and double checked this. I then pinched a section of fat and put the needle into the stomach on site 2. Administered the 6 units until the dial went down to 0, waited 10 seconds. Pulled the needle off and noticed a collection of insulin still in the safety pen, collected at the bottom and noted some on skin.	DOC conversation had instantly with patient. Patient informed me 'thats ok, im a strange person anyway'. Informed patient i would need to contact shift lead - no answer from shift lead. I then rang another band 6. Informed them of incident. Band 6 nurse advised me not to regive as unsure of amount in body. Band 6 advised to recheck BGL later this afternoon. DOC conversation had again with patient once passed on the information from band 6. patient states it was fine and 'not to worry'.	HCA took appropriate actions following human error with administration of medication. Contacted Senior Nurse for advice and apologised to patient for incident. No harm caused to patient. When rechecking in the afternoon, BGL's were raised but this is also normal for patient.	Nil. One off incident due to human error.	Closed
GHC67808	05/04/2024	05/04/2024	20:00	Charlton Lane Hospital	Charlton Lane-Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Hypromellose	No					A dose of a prescribed eye drop appears not to have been given.	This was picked up on a later missed dose medication audit. Modern Matron, Ward Manager and Staff Bank representative were notified.	Managed appropriately in line with missed dose policy Staff who made error made aware No implications to patient, Dr aware	NA	Closed
GHC67810	05/04/2024	13/02/2024	08:00	Charlton Lane Hospital	Charlton Lane-Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Gabapentin	No					A dose of a prescribed analgesia appears not to have been given.	This was picked up on a later missed dose medication audit. Modern Matron, Ward Manager and Staff Bank representative were notified.	Staff bank notified to follow up	Staff to ensure they are recording appropriately on EPMA Discuss dose timings with Dr's	Closed
GHC67845	07/04/2024	07/04/2024	08:00	Wotton Lawn Hospital	Wotton Lawn-Dean Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Ordering, collection or delivery	Sacubitril + Valsartan	No					Unable to give patient prescribed medication due to it being unavailable.	asked other wards if they had it. Informed patient that it was unavailable ordered via pharmacy	Staff advised this is a drug error and should have been avoided Medications must be obtained from the pharmacy as a matter of urgency. If not readily available on the ward or in the hospital, staff can attend pharmacy when it opens, or call on call pharmacist out of hours. All staff remined the importance of ordering prescribed medication in a timely manner to avoid drug errors Staff member involved to complete a reflective account for CPD	N/A	Closed
GHC67856	07/04/2024	06/04/2024	15:00	ICT	ICT Stroud SevernHealth DN	Nursing / residential home	Medication incidents	Medication incident not involving controlled drug(s)	Moderate (significant but not permanent harm e.g. takes up to 1 year to rectify)	Missing medication	Stock balance recording errors / discrepancies	Glycopyrronium bromide	Yes	400mcgs		Subcutaneous	Subcutaneous	called to assess end of life patient who needed medication stat as prescribed. When checking stock found 10 ampoules of Glycopyrronium missing. Carer in charge of shift checked medication cupboard but could not find. He rang staff who reported they were not aware of any medication missing. Patient needed visit from OOG GP to assess and also to prescribe medication as none left in home Also administered controlled drug asked for the care home's log book to record but carer says they do not use this book so unable to comply with completing the records	checked stock sheets in shared care record completed by D/N team carer asked for me to check stock cupboard with him. This was in a chaotic state they had medication in baskets but each basket contained more than one patient's medication. This medication is Just in Case medication containing controlled drugs. There were at least 8 bottles of Oramorph and medication stored in an untidy unsafe way. Could not find the missing medication. reported to shift lead datix completed photograph of medication sheet taken	DN visited on 9.4.24 the following day incident took place and missing glycopyrronium was no longer missing and care home medication store room more organised since previous community nurse visit. CNL has informed care home support to check protocol for home in storing medication.	CNL awaiting confirmation from home manager on process and protocol of storing medication and stock checking medication in the home	Closed
GHC67905	08/04/2024	28/02/2024	20:00	Charlton Lane Hospital	Charlton Lane-Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Paracetamol	No					A dose of a prescribed analgesia appears not to have been given.	This was picked up on a later missed dose medication audit. Modern Matron, Ward Manager and Staff Bank representative were notified.	informed staff bank to follow up with agency RN	Marked as a medication error, agency informed and SN provided reflection	Closed
GHC67930	09/04/2024	08/04/2024	22:15	CYPS/PH Community Specialist	CYPS/PH-Children Complex Care	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug has expired	Administration	Phenobarbital	No					On preparing medication for administration, found bottle of Phenobarbitol currently in use, to have expired on 02/02/2024. Second bottle in use also had same expiry date. Also on checking expiry on other drugs, found a bottle of Paraldehyde had expired on 05/04/2024.	Mum of child informed that both bottles expired. New bottle opened that was in date. Mum informed in morning that one paraldehyde expired.	Thank you for completing this Datix, the correct procedure was followed.	This Datix has been discussed during a team meeting.	Closed
										Drug has expired	Administration	Paraldehyde	No									
GHC67935	09/04/2024	29/02/2024	10:30	ICT	ICT Stroud SevernHealth DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Dalteparin	No					Patient receiving daily Fragmin 5,000 iu. Rang to inform us that appointment was missed yesterday.	Apologies given to patient. Appointment made for this afternoon and ongoing appointments checked. Datix completed. Advised patient to call us on the day of incident in future.	Staff reminded of importance of booking appointment slots in advance as part of each treatment episode. Patient apologised to and advised to raise concerns promptly.	See above	Closed
GHC68007	10/04/2024	09/04/2024	23:00	District Nursing (ENDS)	ENDNS- Out of Hours DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Prescribing	Morphine	Yes	2.5mg and 5mg		Subcutaneous	Subcutaneous	Patient required end of life medication - morphine Checked medication chart on arrival, prescribed drug did not have a start date but had previously been administered to patient.	Contacted shift lead who advised to contact OOH Gp for verbal order to administer medication, ensuring email was sent with patient details prior to giving medication. Advised to add email to patients system 1 notes and ask day team to ensure prescription chart is signed and amended urgently.	reflections requested for both clinicians involved in administration of an incomplete drug chart. documentation power point sent for review	Impact of staffing pressures due to increased vacancy rates within the locality. management to continue to reaffirm 'every contact counts'	Closed
GHC68023	10/04/2024	09/03/2024	14:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Sodium cromoglicate	No					Whilst completing the March missed dose audit, a missed dose was identified during the 2pm medication round.	Email sent to staff bank manager to request a reflection from the nurse responsible for the missed dose.	Reflection received via staff bank	No further lessons identified	Closed
GHC68026	10/04/2024	15/03/2024	22:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Docusate	No					During the March missed dose audit, a missed dose was identified during the 22:00 medication round.	Staff bank manager has been contacted to request a reflection from the nurse responsible for the missed dose.	Reflection received demonstrating learning.	No further lessons identified	Closed
										Drug chart errors - not signed, recording, other	Administration	Mirtazapine	No									
										Drug chart errors - not signed, recording, other	Administration	Paracetamol	No									
										Drug chart errors - not signed, recording, other	Administration	Risperidone	No									
GHC68105	11/04/2024	11/04/2024	08:30	Cirencester & Fairfrd Hospital	Ciren Hosp- Coln Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Pregabalin	Yes	50mg	25mg	Oral	Oral	Medications administered as per usual process for usual 0800 drug round. I noticed that she had a strip of 25mg Pregabalin loose in her pod box. As this was due and she was in pain, I administered this. Due to system one requiring a second signatory (second signatory is not required as not technically a CD) I administered and was going to ask one of my colleagues to be the second signatory at the end of my drug round. In the meantime, my colleague were doing the CD round and saw it had not been given on system one and administered and signed for it.	I contacted the doctor and he has spoken to the patient and assessed her and repeat observations were taken. I also spoke to the patient and apologised as she has capacity and was happy with the explanation given. Manager informed.	discussed at county wide clinical governance 18th april 2024. ward manager on coln to organise a working group to create a SOP for administration and countersigning in the system 1 record,	the wards across the CoHos are doing a different process for administration and the system 1 2nd signature	Closed
GHC68108	11/04/2024	02/03/2024	08:00	ICT	ICT TWNS OT	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Other (unlisted)	Yes	25 mcg	50 mcg	Oral		I recieved a telephone call from a RA to report a medication error so visited property.I arrived at patients house this lunch time to discover yesterday morning 10/04 only one 25mcg stexerol tablet had been given instead of two. It was documented on MAR as only one given and medication count also supported that only one tablet had been given.	Reported to RCO when discovered	thank you for this appropriate datix, theme noted as second datix received for same error with medication administration with this patient	Debrief booked with reablement staff 19/04/2024 and 23/04/2024 to discuss datix investigation and findings discussions held around importance of ensuring correct amount of medications prescribed medication training booked within next 6 weeks for all reablement staff	Closed
GHC68180	12/04/2024	12/04/2024	09:30	ICT	ICT Chelt Town Centre DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Drug has expired	Administration	Insulin human	Yes	30 units	30 units	Subcutaneous	Subcutaneous	Routine visit to administer daily insulin. Upon checking vial (as patient has vials that go into insulin). I noticed that the current vial was out of date. This vial has been used for approx 5 days looking at remaining dose in vial. EXP : 03/2024	Observations checked, informed GP, carers aware. Stock check carried out by myself and carer and all out of date vials of insulin discarded off. Datix completed, Network lead informed and to be discussed at team time.	All appropriate action taken at the time of the visit. To ensure at weekly stock check, that stock dates are checked.	N/A	Closed
GHC68250	14/04/2024	14/04/2024	09:00	ICT	ICT Chelt Town Centre DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Conjugated oestrogens	Yes	10mcg	10mcg	Per vagina	Per vagina	Patient on vagirux pessarys, booked onto appointments to be given on a Wednesday and Sunday, but for unknown reason pessary was given on 7th, 9th, 10th and 12th of April.	datix completed	18/6/24 Staff to ensure they read care plans and Drug charts as also has Daily Insulin administration. Clear now on S1 visits that pessary due Wed/Sundays so error avoidable in future	18/6/24 staff aware to reflect and take time to review charts & care plans effectively & no harm to patient occurred	Closed
GHC68256	14/04/2024	14/04/2024	11:00	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Morphine	Yes	30mg	30mg	Subcutaneous		Visit to patient for end of life care and replenish syringe driver, noticed that drug chart had not been completed or signed for previous day for syringe driver.	photographed drug chart. Re checked system one records for cross reference of medication given yesterday. complete datix. unable to upload photograph at present.	Reviewed system one documentation - notes clear and concise Spoke to staff member who had not signed chart - human error, home was busy with family members and nurse was distracted Advised to be more careful - documented conversation - added to staff members P-file	Human error- documentation on S1 is clear Staff member aware of the importance of signing the chart will add in additional checks on future visits	Closed
GHC68262	14/04/2024	14/04/2024	09:10	ICT	ICT Chelt St Paul's DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Insulin glargine	Yes	10	12	Subcutaneous	Subcutaneous	Arrived to give insulin - Saw chart had been re-written and crossed out and new directions added onto the bottom of the chart. This stated hte amount to give if BGL were below or above. The care plan as well stated this however the care plan put a different number than the drug chart. This resulted in the patient not receiving the full dose of insulin they were due. Administered 10 units but required 12.	Contacted another nurse who had met patient. Talked through the drug chart and explained what it stated. Patient BGL were within range and was talkative and alert and stated they felt well in themselves. Sent task to GP to request a new drug chart to be written up to avoid further confusion. Informed the network lead. Spoke with nurse who administered yesterday.	All appropriate action taken at time of identification. further discussion had with clinician who commenced care plan. clear human error when typing. reflection actioned.	n/a	Closed
GHC68294	15/04/2024	13/04/2024	20:25	Montpellier Secure Inpatients	Montpellier Low Secure Unit	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong time / frequency	Administration	Paracetamol	Yes	1 gram		Oral		Patient administered paracetamol at 20:25 instead of 22:00		Email sent to nurse (Bank worker at time of incident) and Temporary Staffing manager (substantive manager unknown) advising of medication error, the detail of the error and actions to be taken as per Trust Medication Error policy (policy attached to email).	Not applicable	Closed
GHC68329	15/04/2024	27/03/2024	10:00	Complex Care at Home	Complex Care at Home FOD	Pharmacy-community	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Pharmacy	Olanzapine	Yes	5mg		Oral		Patient received wrong medication from pharmacy, patient was prescribed memantine by GP and was given Olanzapine from the Pharmacy. Box was branded with Olanzapine and labels stated Memantine	Family had contacted GP and Pharmacy, Pharmacy reported that they will do there own internal review	Incident identified and escalated to GHC pharmacist	Diligence from GHC staff prevented further drug errors	Closed
GHC68387	16/04/2024	09/04/2024	01:00	ICT	ICT Stroud BerkeleyVale DN	NHS 111	Medication incidents	Medication incident involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong quantity	Administration	Oxycodone	Yes	5mg	0.65-1.25	Subcutaneous		Visited patient for syringe driver replenishment. Patient reports more lethargy and additional 'shaking' this morning Had received visit from OOH nurses overnight and OOH GP, both of which administered PRN medication. Noted GP had administered 5mg Oxycodone, prescription chart range was 0.65-1.25mg	Advised patient of additional medication which had been administered. Discussed ongoing range for medication. Informed shift lead. Own GP scheduled to review this afternoon already.	Thank you for taking the time to complete this datix GP's are allowed to administer what they feel appropriate at the time so no error made. Gp had signed the chart and documented amount given. Chart has since been change to increase dose on chart	No lessons to be learnt at this time	Closed
GHC68394	16/04/2024	16/04/2024	11:30	ICT	ICT Glos Inner City DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Morphine	No					Arrived to do bladder and bowel care for patient. While in patients home I asked family to check the shared care folder and the JIC meds due to family saying patient had secretions. No morphine sulphate 10mg/ml in home however 5 ampoules have been prescribed and counted on stock sheet.	Informed the family - they contacted another member of their family and apparently he had taken a bag of unused medication that belonged to the patients spouse to the pharmacy for disposal and feel the box of morphine sulphate must have been put with spouses other medication by mistake. Family member went back to pharmacy to see is medication could be retrieved - medication had been destroyed. Will email surgery requesting another box of 5 ampoules.	On review of notes and speaking with Nurses who attended the home family had taken medication to pharmacy to be destroyed along with Mums medication who had recently passed away. Medication taken back to pharmacy was human error. No further action.	No new lessons.	Closed
GHC68398	16/04/2024	29/03/2024	09:00	Recovery Units	MH IP Rehab-Laurel	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong / unclear dose or strength	Administration	Lorazepam	Yes	2mg	1mg	Oral		Patient was given 2mg of Lorazepam instead of 1mg	Error was not noticed until several hours after the medication was administered but staff reacted to patients presentation as soon as it changed. Patient became very sleepy and difficult to rouse. Put on 15 minute observations, NEWS completed and Doctor informed. Now error has been recognised, protocol is being followed	Discussed incident with staff nurse involved. Staff Nurse has completed written reflection around the incident. Supervised medication round to be completed with DWM. Patient aware of incident and apology given. Doctor aware an informed so that patient well-being and safety was considered.	Staff to be vigilant and mindful when administering medication to ensure that correct medication is administered as prescribed.	Closed
GHC68403	16/04/2024	15/04/2024	08:30	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Insulin lispro	Yes	25 units		Subcutaneous		Visit to patient for insulin administration and BGL monitoring. Administered 25 units of insulin via pen device, with safety needle attached and pre primed with 2 units. After administration i noticed a pool of insulin within the safety needle shield. I was concerned that the complete dose had not been administered.	I advised patient of this and reassurance given. I advised that BGl may increase over the day as may not have had complete dose of insulin due to fault with needle.I contacted GP at surgery and discussed. GP advised that as impossible to estimate the amount given, it would not be safe to have an additional dose today. Patient had reported hypo overnight and BGL was 6mmols at time of visit. Patient already had evening visit booked for BGL monitoring and evening insulin dose, GP advised that BGL may be higher later in day, which was safer and no further intervention needed with evening visit in place. Advised shift lead of incident. Note added to appointment for nurse visiting in evening to advise of this. Datix completed.	There have been a couple of issues with these safety needles. Email to GP to order a different type of safety needle cto prevent further issues.	Appropriate action taken, staff are trained however this particular brand does cause some leakage of insulin.	Closed
GHC68407	16/04/2024	16/04/2024	16:00	Wotton Lawn Hospital	Wotton Lawn-Kingsholm Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong formulation	Prescribing	Olanzapine	Yes	20mg		Oral		Patient has incorrectly received multiple prescribed oral antipsychotics this morning. The patient should have received: 5mg Diazepam 5mg Haloperidol 30mg Lansoprazole 250mg Naproxen 150mg Sertraline There was a discussion in ward round about starting Risperidone however this was not agreed once patient reviewed. Risperidone had already been prescribed at 11:14 and discontinued at 11:31. Nursing staff had given Risperidone signed for at 09:41. Plan from ward round was to reduce ON dose of Olanzapine from 20mg to 10mg and add in 5mg Haloperidol with cross titration regime. On the prescription chart ON Olanzapine had been reduced to 10mg however 20mg Olanzapine had also been prescribed OM and this had been given by nursing staff. 5mg Haloperidol prescribed and given correctly.	Telephone call made to RC & SAS with the following plan: - Complete NEWS2 physical observations every 4 hours - escalate if clinically indicated and document any refusals on NEWS2 chart. - Complete non-contact physical observations if pt refuses contact observations. - Monitor signs and symptoms of NMS - Regularly ask patient if he is experiencing any of the above or reports of feeling generally unwell/stomach pain and report to duty doctor. - Stop Olanzapine 10mg ON that is prescribed for tonight. - CT1 doctor making duty doctor aware of above incident - patient is not to receive any more antipsychotics this evening. - Complete Datix. - Complete Duty of Candour.	- Duty of Candour done and patient informed of the error - Steps taken to monitor side effects and night dose of medication omitted. - No adverse affects documented in patient notes in days following incident	- To closely check and ensure that discontinued medication is clearly stopped on e-prescribing	Closed
										Wrong formulation	Prescribing	Risperidone	Yes	2mg		Oral						
										Wrong formulation	Administration	Olanzapine	Yes	20mg		Oral						
										Wrong formulation	Administration	Risperidone	Yes	2mg		Oral						
GHC68414	16/04/2024	16/04/2024	19:25	Wotton Lawn Hospital	Wotton Lawn-Dean Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Metformin	Yes	2 gram	1 gram	Oral		Patient due 1gram metformin Staff accidentally administered 2 gram metformin and realised after patient had accepted the medication Duty doctor contacted Duty doctor aware and has no concerns	Staff apologised and was honest with patient	No harm to patient Discussion had with patient Staff member involved completed supervised drug round and reflective account of incident	No obvious external factors contributed to incident, human error	Closed
GHC68475	17/04/2024	17/04/2024	11:00	PICU	Wotton Lawn-Greyfriars PICU	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong route	Administration	Haloperidol decanoate	Yes	150mg	150mg	Intramuscular	Intramuscular	Haloperidol depot administered in the arm, which is not a licenced site for this medication to be administered.	Medics informed.	Pharmacist informed and ward medical team made aware. Nursing staff advised to read on administration guidelines on Haloperidol.	To ensure nursing staff are following the appropriate guidance.	Closed

GHC68477	17/04/2024	17/04/2024	10:30	PICU	Wotton Lawn-Greyfriars PICU	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Clozapine	Yes	400mg	oral	Oral		Clozapine dose not signed for.	Bank nurse contacted to confirm whether medication had been given, as EMPA reflected it hadn't however rio notes stated it had. Upon clarification bank nurse advised patient initially refused, however did later accept medication off another member of staff, however this was not recorded in EMPA.	1-1 with staff member, Discussion with staff member's manager and staff advised to complete reflection,	Reflection from staff,	Closed
GHC68511	18/04/2024	18/04/2024	12:00	Charlton Lane Hospital	Charlton Lane-Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Rivastigmine	Yes	9.5mg/24hrs	9.5mg/24hrs	Topical	Topical	staff were going to put medication patch (Rivastigmine 9.5mg/24hrs transdermal patch). staff noticed 2 other previous patches.	patient was checked for any other patches on her body. only 2 patches were seen. both patches were removed and a new patch (18/04/24).	Managed appropriately Escalated to management team	NA	Closed
GHC68515	18/04/2024	05/03/2024	14:30	ICT	Reablement Stroud	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Administration	Other (unlisted)	Yes	unknown	unknown	Oral		OT did phone review with patient daughter. The daughter highlighted that she thought she had discovered a medication error a few weeks earlier. Daughter stated her mum told daughter that she needed some more tablets. Daughter checked when visited the house and thought that The reablement team had been prompting the patient to take the water tablet which was prescribed before hospital admission (began with A) and the new water tablet (began with L) prescribed from ho0spital. Daughter does not know if this definitely happened or how long for. Daughter told OT that mum had once or twice said she felt "odd" but otherwise no change in health. daughter had sorted the tablets , so that only one type of water tablet was now being taken.	OT emailed Reablement Coordinator to advise of incident in the recent weeks and OT to complete a datix when able to then set a review of the situation/ what had happened. Private care provider supported the patient the first few weeks at home.	Appropriate action taken at time of incident	Since incident has occurred there has been new medication paper work and training for the home first & Reablement team which should minimise the risks of this recurring	Closed
GHC68516	18/04/2024	12/04/2024	10:00	Long Term Conditions	Cardiac Rehabilitation Service	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Contra-indication in relation to drugs or conditions	Prescribing	Sildenafil	No					Noted patient prescribed Sildenafil on discharge from hospital despite recent myocardial infarction. See discharge summary printed 23/02/24 and 07/03/24.	Spoke to wife and advised her to tell patient not to take Sildenafil and to get advise from the pharmacist or GP.	Cardiology Pharmacist at Gloucestershire Hospitals contacted to flag and investigate. Informed the used for ED the SPC states that patients who have been successfully revascularized (eg PCI) are considered low risk. SP enquired if this was the same guidance for all ED medication, MJ response 'the SPCs for the other PDES ED treatment don't specifically include this statement but it would be reasonable to apply it to the class'. Requested incident shared with Organisation responsible.	Findings shared with Cardiac Rehab team at team meeting.	Closed
GHC68517	18/04/2024	28/02/2024	16:20	Later Life	Later Life North	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Prescribing	Flupentixol decanoate	Yes	90mg every 2 weeks	90mg every 2 weeks	Intramuscular	Intramuscular	Routine pharmacist check of community depot prescription cards. One patient was prescribed flupentixol 90mg every 4 weeks but it was being administered every 2 weeks. Previous prescription was 90mg every 2 weeks	Checked RiO - no information that dose had changed. Checked with care coordinator and Dr - no change had occurred. Care coordinator to arrange for the prescription to be rewritten the following day			Being Reviewed
GHC68520	18/04/2024	11/04/2024	13:26	ICT	ICT Chelt St Paul's DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Insulin isophane biphasic human	Yes	8 units	8 units	Subcutaneous	Subcutaneous	- Patient called in to triage and advised had not had her morning insulin - No visit booked for 16/4/24	- Apologised that no visit had been booked - Allocated someone to get to patient as soon as possible - Nurse attended within 20 minutes	Apology to patient. no duty of candour required as non harm incident. Last visiting clinician requested to provide a written reflection on incident of no ongoing visit bookings and impact on patient care. leads advised to raise at team time for learning for all of the team.	n/a	Closed
GHC68529	18/04/2024	18/04/2024	13:30	Rapid Response & EONS	Rapid Response	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Drug prescribed with known allergy	Prescribing	Trimethoprim	Yes	200mg		Oral		Pt prescribed Trimethoprim for CAUTI, patient has various medication allergies. Prescribed by B7 prescriber. I supplied the Trimethoprim to the nursing home and 1 x tablet was given orally. I had initially looked at the Allergies on her medication chart and could not see Trimethoprim on it. Whilst checking through the pt care summary I noticed Co-Trimoxazole listed as an allergy. I checked the active medications combined in this drug and realised that one of them was Trimethoprim. Her reaction to Trimethoprim is noted as rash with raised temperature.	Discussed with prescriber. Discussed with nursing home staff. Family to be made aware of the incident. GP to be contacted.	All necessary actions taken, duty of candour followed.	none	Closed
GHC68537	18/04/2024	09/04/2024	21:00	District Nursing (ENDS)	ENDNS- Out of Hours DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Drug chart errors - not signed, recording, other	Administration	Levomepromazine	Yes	2.5mg,5mg, 20mg and 30mg		Subcutaneous		Visited patient in out of hours as patient symptomatic with pain and respiratory secretions. Incorrect start date on prescription charts, medication had previously been administered.	Contacted shift lead who advised to contact OOH Gp for verbal order. Administered medication required following clarification of email from Gp. Offered apologies for delay in treatment to family.	% clinicians involved requested to reflect in written format to be saved to their P files in relation to drug error. presentation formulated by CNL team emailed for review of documentation expectations.	Impact of excessively high vacancy rates and burn out impact on staff wellbeing and human error occurrences.	Closed
GHC68538	18/04/2024	18/04/2024	20:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong patient	Administration	Olanzapine	Yes	7.5	2.5	Oral		Patient received medication belonging to a different patient.	Following Duty of Candour and the Being Open policy principles Duty Doctor was informed, NEWS taken and patient and family member informed and apologies were given. Nurse in charge informed as well as Datix filled in. Duty Doctor classified drug error as no harmful but may cause extra sedation overnight. Staff nurse will write in a reflective review.	Nursing team followed correct process following identification of error. Nurse involved has completed reflection and new competency for meds. HCA involved has completed new competency.	Staff involved reflected and learnt from events to improve future practice.	Closed
GHC68588	19/04/2024	19/04/2024	12:00	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Ordering, collection or delivery	Clotrimazole	Yes	1 x 200mg pessary		Per vagina		Visit to patient for administration of vagifem pessary and cannestan pessary. Records written from previous visit report stock of cannestan pessary should be 2 left. On checking, there was only 1 cannestan pessary, in addition there was an empty sealed blister which had writing printed on it to say 'no medication, empty blister'. The cannestan was written on drug chart being prescribed for 7 days. Patient had 5 doses prior to today. In addition, both the pessaries were written on an anticipatory medication chart, which after my visit, then had no further space to sign and the vagifem pessary was prescribed for 14 days.	I checked with care staff re stock of cannestan received. It appeared that 2 boxes, each having 3 pessaries, were received on two separate occasions. I requested a further cannestan pessary be dispensed from the surgery, and also requested GP writes up new drug chart, using a green medication chart. I liased with shift lead to ensure chart would be collected today, prior to weekends visits.I advised DN visiting tomorrow of situation and advised again when drug chart had been collected and delivered to property.	review of notes, discussion with reporting nurse no concerns re safety of patient and medication missed opportunity to get chart rewritten in timely manner however this did not disrupt medication routine	Drug charts and timely rewriting - means less delay and visits for another nurse - everyone's responsibility . TL's to share in team time	Closed
GHC68609	20/04/2024	20/04/2024	08:00	Charlton Lane Hospital	Charlton Lane-Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong method of preparation	Administration	Atorvastatin	No					early shift staff nurse was doing the medication round, staff noticed medications(5 tablets- 1 white oval tablet, 2 white round tablets, 2 small pink tablets) left in patient's medication tray.	staff checked the extended view of the previous day medication, noticed that medications were recorded as given. datix completed.	Managed appropriately	NA	Closed
										Wrong method of preparation	Administration	Cyproterone	No									
										Wrong method of preparation	Administration	Lisinopril	No									
										Wrong method of preparation	Administration	Mirtazapine	No									
										Wrong method of preparation	Administration	Risperidone	No									
GHC68613	20/04/2024	20/04/2024	12:00	ICT	ICT Stroud BerkeleyVale DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Oxycodone	Yes	5mg	0.65-1.25	Subcutaneous	Subcutaneous	Visit to replenish syringe driver noticed stat dose given yesterday was too much nurse gave 5mg - dose prescibed was 0.65- 1.25 OOh GP visited on 16/4/24 and also administered 5mg, appears nurse has followed his dose	spoke to family and advised what had happened, patient ok, and daughter feels patient needed the bigger dose to control pain Note left for nurse visiting monday to get chart amended	Call to reporter and reviewed notes. Community nurse responsible for the error, meeting set up. Community Nurse accepted responsibility and apologised for the mistake. Agreed to re-do medicine management module, write a reflection which will go on the P-file and have clinical supervision with her line manager for stat doses. No harm to patient and Stat dose has been reviewed and increased to the higher dose.	Advised Nurse to take her time and read through Drug charts properly. To avoid copying and making mistakes.	Closed
GHC68621	20/04/2024	02/03/2024	10:00	ICT	ICT TWNS OT	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Spironolactone	Yes	50mg	25mg	Oral	Oral	Rehabilitation assistant reported to me this morning 20/04 that he noticed a wrong dose of medication was given to patient yesterday morning 19/04. A full 50mg spironolactone tablet was given instead of the correct dose of 25mg once daily for which the tablet needs to be spilt.	I called 111 for advice , a technician called me back asking if the patient had shown any side affects, i explained to him none had been noted by the staff this morning. He explained the patient should not show any adverse side affects but to observe patient and to call 111 if any mild side affects noted and to call 999 if any severe side affects were presented. All staff visiting patient have been made aware to observe and contact relevant services if required.	thank you for this appropriate datix, new strength medication was taken into the property monday, therefore meaning the tablet was not needed to be halved to reduce medication error risk OOH 111 services were contacted and the safety of the patient was ensured	debrief with reablement staff undertaken 23/05/2024 identification of alternative medication doses to be obtained to prevent errors discussions were held around highlighting alternate doses on the mar chart although further discussions around complacency in expecting highlighted information all reablement staff have medication training booked within 6 weeks	Closed
GHC68652	21/04/2024	21/04/2024	10:30	ICT	ICT Cotswold South 2 DN	Care agencies (home care)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Drug administration omitted / delayed	Administration	Atorvastatin	No					On arrival at patients home, was told by the patient that the carer that had just visited had given her the evening medication from the Dosset box and not the morning medication. Carer was not at the property during my visit. But was told from the patient that the carer was going to call the OOH GP and report back to her office.	Checked the medication, Rang the RC No details of care agency and patient did not know who they were to call. Rang patient back to check the carer had been in touch as was asked to take the medication that needed to have that morning.	Notes reviewed and called up care company involved in this error. I was assured it was being look into it and was told the care manager would call me back but i have had no call. Presume now the error was raised through their incident reporting system and dealt with appropriately.	Important to raise these issues quickly so they can be identified and dealt with and anything to help prevent the situation happening again such as further training.	Closed
										Wrong time / frequency	Administration	Clopidogrel	No									
										Wrong time / frequency	Administration	Lercanidipine	No									
GHC68692	22/04/2024	18/04/2024	17:06	Crisis Resolution Home Treatmt	CRHT Chelt & Tewks	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Prescribing	Nitrazepam	Yes	10mgs PO BD	BNF limit	Oral		Patient was prescribed 10mgs BD of Nitrazepam for a week by the Crisis Teams SAS doctor. The maximum dose of Nitrazepam is 10mgs in 24 hours. The prescriber had also prescribed Zopiclone without first checking the efficacy of Nitrazepam first.	As the consultant for the team I called the patient and it was then that she informed me about the dose she had been prescribed. She did not report any adverse affects of taking the increased dose. I have advised her to reduce her dose back to 5mgs BD immediately.	CRHTT Consultant spoke with patient and informed of correct dose CRHTT Consultant spoke through prescription error with prescriber	No lessons learnt No harm caused	Closed
GHC68709	22/04/2024	21/04/2024	18:00	Rapid Response & EONS	Rapid Response	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Adrenaline	No					Stock check on medication in Rapid Response drug cupboards at ILC. Stock discrepancies involving 11 different medications	Reported to Rapid Response band 8a on Monday 22/04/24	Drug cupboard, drug bags and medicines management being reviewed by Matrons	Review of medicines management required	Closed
GHC68733	22/04/2024	22/04/2024	19:46	Charlton Lane Hospital	Charlton Lane-Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Monitoring / follow-up of medicine use	Dalteparin	Yes	5000	5000	Subcutaneous	Subcutaneous	female patient was given dalteparin 5000 unit subcutaneous injection at 18:40 after it was discontinued at 16:50. when the page got refreshed after documenting the medication, it appeared as the medication was discontinued. the medication was accidently recorded as given at 19:40, but was actually given at 18:40 (could not document soon after giving as the rio page got stuck and was buffering), when staff tried to redocument to change the time, to enter it as "entered in error", the medication given did not appear.	when this incident happened, staff informed the patient regarding the error. physical observations were done.NEWS2-0. duty doctor was informed and datix was completed.	No concerns following medication being given, had not been communicated that	NA	Closed
GHC68744	23/04/2024	22/04/2024	16:10	CYPS/PH Community Specialist	CYPS/PH-Community Nursing	Other organisation (please specify)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Methotrexate	Yes	20mg		Subcutaneous		Home visit with third year student nurse to administer weekly Methotrexate sub-cut pre-filled pen injection. Student nurse attempted to administer injection into child's left thigh. Myself and student heard first click from pen device but no medication was administered and no second click heard. On examination no puncture mark from needle seen on child's thigh. Attempted to administer same injection again but plunger had locked so unable to administer. Therefore new pen device needed to be used.	First pre-filled pen device discarded into cytotoxic sharps bin. New pen device used. Mum informed of faulty pen-device and aware a datix will be completed. Email Gloucester rheumatology specialist nurse to inform her of faulty pen-device. All documented in child's records.	appropriate action taken by nurse visiting, child received medication. Would repeat the same procedure if this happens again to alert rheumatology nurse specialist who oversees patient's care to potential faulty batch of pen devices.	appropriate action taken.	Closed
GHC68745	23/04/2024	10/03/2024	02:51	Psychiatric Liaison	MH Liaison Alcohol Inpatients	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Prescribing	Diazepam	No					Patient completed the initial 24 hours of CIWA requiring 59mg diazepam, a further 7mg diazepam given post 24 hours. Intermediate level detox indicated post 24 hours however, this has not been commenced.	Raised with manager regarding concern	Shared with GHFT and discussed at joint GHC/GHFT risk governance. Closed pending GHFT response.	Dependant upon GHFT investigation and outcome.	Closed
GHC68746	23/04/2024	23/04/2024	09:00	Psychiatric Liaison	MH Liaison Alcohol Inpatients	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Prescribing	Diazepam	No					Patient self discharged and then was readmitted to ED within hours. No new CIWA initial 24 hours scoring was commenced instead the reducing regime that had been started during the last admission was continued once patient got to the ward despite there being a 2 day gap between doses. also unclear if any diazepam was given in ED as no prescription for this on EPR.	reviewed by team and raised with manager. team will review with the ward	Discuaeed at IRSH, shared with GHFT and raised at joint GHC/GHFT risk governance forum. Closed pending GHFT response.	Dependant upon GHFT investigation	Closed
GHC68762	23/04/2024	23/04/2024	12:00	ICT	ICT Cotswold North DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Buprenorphine	Yes	Bunov 10 microgram/h transdermal patch	10mcg/hr	Topical	Topical	Nurse visited patient to change weekly Bunov 10 microgram/h transdermal patch (buprenorphine medication). When checking medication stock identified that an error in how many patches were documented on previous entry. Patches come in a box of 4 and it had been documented that there were 5 patches. Checked previous entries and took photograph of stock chart to add to this incident report for clarification.	Stock check of medication, checked drug chart was all in order, discussed with Team Leader and informed of medication documentation error and raised a datix for caseload holder to review.	Accountable drug documentation error as discussed with nurse who visited and recorded 5 patches on stock sheet and she thought sealed box when she opened it has 5 patches in. Box comes as a box of 4 patches. Picked up by nurse at next visit that miscounted at previous visit.	Highlighted error to RN and will be more cautious in future.	Closed
GHC68818	24/04/2024	23/04/2024	19:30	Charlton Lane Hospital	Charlton Lane-Chestnut Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Oxycodone	Yes	10ml	10ml	Oral	Oral	Newly admitted patient was prescribed with oxycodone hydrochloride 10 mg capsules initially which was out of stock in hospital and only oral liquid was available in mulberry ward . therefore the prescription changed to liquid and oxycodone hydrochloride oral liquid preparation 10 ml borrowed from mulberry ward to give to patient and 10ml administered .remaining returned back to staff nurse mulberry ward	administering nurse to do Datix and make sure that POPAM and CD Drug administering policy will be followed while administering controlled drugs.	The member of staff has been seen the ward manager and has been asked to confirm her knowledge of the policy also to complete reflection.	To ensure all trained nurses are up to date with policies	Closed
GHC68820	24/04/2024	23/04/2024	19:30	Charlton Lane Hospital	Charlton Lane-Chestnut Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Oxycodone	Yes	10ML	10ml	Oral	Oral	Newly admitted patient was prescribed with oxycodone hydrochloride 10 mg capsules initially which was out of stock in hospital and only oral liquid was available in mulberry ward WHICH BELONG TO ANOTHER PATIENT IN MULBERRY . therefore the prescription changed to liquid and oxycodone hydrochloride oral liquid preparation 10 ml borrowed from mulberry ward to give to patient and 10ml administered .remaining returned back to staff nurse mulberry ward	administering nurse to do Datix and make sure that POPAM and CD Drug administering policy will be followed while administering controlled drugs.	Ward sister has discussed the policy with the staff member and she will complete reflection.	The medication was not available on the night shift and the staff member tried to help the patient but now knows the policy.	Closed
GHC68879	25/04/2024	23/04/2024	16:30	North Cotswolds Hospital & GMC	NC Hosp-Cotswold View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong drug / medicine / item	Administration	Oxycodone	Yes	10mg Oxycodone Longtec	10mg Oxycodone Short release	Oral	Oral	Incorrect Oxycodone medication was administered. Patient is prescribed Oxycodone capsules 5mg-10mg no more than 40mg in 24 hours on the as required medications. Patient has her own Oxycodone in the Controlled Drug cupboard Patient was administered Oxycodone 10mg Longtec - tablet from the ward Controlled Drug cupboard. This is the incorrect medication	Apologised to the patient for the incorrect medication administered. No harm caused to the patient	On review of this incident it has highlighted X2 confirmed drug errors and a near miss. On review of this incident there has been confirmed no harm to the patient. Correct procedure was followed at the time of the error being identified. To prevent recurrence the colleagues involved with the errors have completed a personal reflection in addition to completing the online Controlled Drug Administration E-learning.	On review of this incident it has highlighted that there was minimal reason for this error to occur. The drug was prescribed correctly and there was ample patient own drug available to be used. All staff involved with the incident have completed the relevant online controlled drug e-learning to prevent occurrence and performed their own reflections. Regular updates through ward safety brief to limit risk of more drug errors occuring.	Closed
GHC68888	25/04/2024	11/03/2024	22:00	Charlton Lane Hospital	Charlton Lane-Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Paracetamol	No					A night time prescribed dose of paracetamol was not recorded as administered	This was picked up during the Ward monthly missed dose audit. Modern Matron and Ward manager informed, and the administrating Nurse will be asked to complete a reflection.	Managed appropriately	NA	Closed
GHC68890	25/04/2024	15/03/2024	22:00	Charlton Lane Hospital	Charlton Lane-Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Paracetamol	No					A night time prescribed dose of paracetamol was not recorded as administered.	This was picked up during the Ward monthly missed dose audit. Modern Matron and Ward manager informed, and the administrating Nurse will be asked to complete a reflection.	Managed appropriately in line with missed dose policy	NA	Closed
GHC68907	26/04/2024	22/04/2024	16:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Preparation by administering clinician(s)	Diazepam	Yes	6mg throughout the day	4 mg throughout the day	Oral	Oral	Diazepam was given to patient for a second PRN dose when the prescription chart stated diazepam to be given once daily.	Patient was made aware as this was notice the day after the error. Medics were informed to make them aware in the case of any adverse drug reactions however none were noted. Reported to the management team and completing a reflection for this.	Nurse has completed new medication competency and reflection demonstrating learning from incident.	No further lessons identified.	Closed
GHC68910	26/04/2024	22/04/2024	16:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong method of preparation	Preparation by administering clinician(s)	Ibuprofen	Yes	1200mg	1200mg	Oral	Oral	Patient's dossett box was incorrect due to a new prescription started following the arrival of the dossett box. Therefore patient may not have had accurate doses of pain relief medication.	Medics were informed to make them aware in the case of any adverse drug reactions however none were noted. Reported to the management team and completing a reflection for this. Patient to be made aware of this following this error. Dossett box returned to pharmacy due to not being accurate following prescription chart change.	Nurse has completed new meds competency and reflection demonstrating learning. Discussion with consultant around medics amending medication whilst patient is using dossette box as has been repeated issue.	No further lessons identified	Closed
GHC68916	26/04/2024	26/04/2024	11:10	Working Well	Working Well-Occ. Health	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Diphtheria + Tetanus + Pertussis + Poliomyelitis vaccine	No					Administering repevax. Needle disconnected from syringe, full dose not administered, small remaining amount leaked.	Informed OHA on duty-consulted UK health security agency for guidance, informed client who chose not to have another dose as set out by guidance- but aware may contact working well at anytime if changes mind.	Batch of needles removed from use Conversation with Nurse Period of supervision arranged	?? Faulty Batch of needles	Closed
GHC68942	26/04/2024	26/04/2024	11:30	ICT	ICT Glos North South DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Midazolam	Yes	30mg		Subcutaneous		Visit to replenish syringe driver. While checking midazolam ampoules stock sheet said there were 8 ampoules in home of 10mg/2ml but I could only count 5. There were three ampoules of 2mg/2ml in home, I wonder whether these were wrongly counted in with the 10mg ampoules.	As not enough ampoules of midazolam left in home for tomorrow I sent urgent request to surgery for more ampoules. Datix completed for discrepency.	- Review of S1 records. - Explanation from nurse seems likely. - Was going to suggest removing the 2mg amps. - However noted patient passed away 27/4/24. - No further action needed.	- Vigilance needed with medication stock counting. - Reiteration needed at 121, team times and band 6 meetings. - To discuss at band 6 meeting this week for escalation.	Closed
										Drug administration omitted / delayed	Administration	Apixaban	No									

GHC68988	28/04/2024	28/04/2024	09:00	ICT	ICT Cotswold North DN	Self-care	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Drug administration omitted / delayed	Administration	Dapagliflozin + Metformin	No					Arrived at patients home - carer present. Carer has been sent solely to look for missing daily regular medication from morning carers. I saw dosette boxes on table yesterday x2. these have now gone. patient states no one has been in the home - only carers. Myself and carer look around the home. Patient then calls his partner who does not live with him. She was in fact at the home with him yesterday and threw the dosette boxes away. she states they were empty and now in recycling. I checked the recycling bag and they were not there. BGL now 33.3 - oral diabetic meds missed.	Obs checked and patient feeling well. T/C made to OOH GP - unable to make dosette box up for today but would arrange single medication boxes to be collected. Made aware of high BGL and will return this afternoon to recheck. Called SQ carers also who are happy to administer from these boxes and will collect today from moreton pharmacy. Thanked me for helping them.	All actions taken leading up to, during and after the incident were well managed. Patient being seen by district nurses for insulin as patient was struggling to manage at home following failed discharge from hospital. Safeguarding raised and many discussions with GP to raised concerns.	Learning regarding failed discharge has been discussed with discharging hospital.	Closed
										Drug administration omitted / delayed	Administration	Ramipril	No									
GHC69001	28/04/2024	28/04/2024	13:00	ICT	ICT Stroud Cotswolds DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Ordering, collection or delivery	Oxycodone	Yes	20mg via syringe driver	20mg	Subcutaneous	Subcutaneous	15 oxycodone ampules counted in on the 27th at 13,00. DN set up driver at 18.45 stock level was 14- 2 used 12 remaining. 28th SD set up only 7 amps remaining of oxycodone, 1 box was empty.	Discussed with nurse who visited at 13,00 and counted in stock, all boxes appeared sealed and no stock left in home. I was the nurse setting up the driver, two boxes sealed and 1 open with 4 amp inside.	Discussed findings with visiting nurse. Charts were obtained via Hospice where patient now is and unable to load as deleted in email by error. However on review of charts and discussion with nurse who submitted Datix, stock level count of Oxycodone was recorded by checking what is issued but without opening the sealed box. It is possible that there was not the issued amount in the sealed box.	Staff acted appropriately in checking and reporting this incident.	Closed
GHC69025	29/04/2024	26/04/2024	11:20	Working Well	Working Well-Occ. Health	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Measles + Mumps + Rubella vaccine	Yes	possibly half	0.5ml	Intramuscular	Intramuscular	administering MMR vaccine, syringe detached from needle part way through administration via IM route, and vaccine leaked-therefore full dose not received	informed managers, spoke with client about options and plan for further vaccines made-lot of needles 02109088 exp 2026-10-15 removed from clinic room and stores-batch number to be investigated	Batch of needles removed Discussion with nurse and Supervision arranged	?? Problem with batch of needles	Closed
GHC69028	29/04/2024	29/04/2024	10:20	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Preparation by administering clinician(s)	Ibuprofen	No					Checking patient Dosette box with colleague this morning and realised that ibuprofen tablets was prescribed as 400mg 3 times a day on checking we found the 2 tablets of 400mg - 800mg was found.	Phone call to Pharmacy to notify them of this error and medication will be sent back to pharmacy. manager of the ward has been informed. Patient medication was self administer this morning with dosette box.	Dispensing and checking error. Fed back to staff involved who have completed reflective accounts.	0	Closed
GHC69068	30/04/2024	24/04/2024	13:30	ICT	ICT Cotswold South 2 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong quantity	Administration	Morphine	Yes	14.8	approx 20mls should have gone through	Subcutaneous		Visited patient routine replenishment of syringe driver. On arrival son told me that the pump had been alarming repeatedly, and that they had been resetting it as per previous instructions when family phoned in for alrm going off. Completed syringe driver check chart identified that medication has not been administered within the appropriate timescale and is several hours behind. Specialist nurse visited earlier in the day and given as required medication as patient is feeling very nauseous and uncomfortable.	Syringe driver stopped and replaced with a new syringe pump. Butterfly cannula removed and found to be bent at a 90 degree angle. New syringe,line and butterfly needle used and old equipment disposed off. Syringe driver sent to medical engineering to be checked that is working correctly. Patient offered additional is required medication but did not wish to have it at this time. Family advised that if the pump alarms repeatedly to ring the referral centre and ask for a visit to review in person. Remaining driver contents disposed of in controlled drug destruction pot	Thorough assessment and documentation of events regarding syringe pump delivery due to saf T intima tissuing and being dislodged Education given to family regarding escalation to ENDNS if there was persistent alarming from syringe pump At time of assessment resited saf T intima and syringe replenished - safe disposal of undelivered medication completed as per policy	Notes reviewed and visiting nurse 23/04/24 did not document site assessment of syringe pump but subsequently documented 24/4/24 that she had offered resiting of pump and patient had declined - will discuss with team member about clinical decision making for best outcome for patient Need to emphasise to relatives and patients that if recurrent alarming from syringe pump needs escalation to DN team for review	Closed
GHC69080	30/04/2024	29/04/2024	23:40	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Paracetamol	Yes	1gram		Oral		I wanted to give medication for 08:00hrs and saw that patient was given a total dose of 5g of Paracetamol and the maximum dose was 4g in 24hrs yesterday. She was given another gram from Discretionary.	I omitted the morning dose and physical observations were done. NEWS Score was 0 and patient was Alert. Patient was informed about the incident and the reason why I was omitting the dose and reflected duty of Candour. I called the Doctor to inform her of the incident that occurred and she came and reviewed her. She collected bloods and were sent to laboratory. Further review - To follow toxic staggered paracetamol protocol - discussed with CGH Medical registrar, who - advised for transfer to ED if patient has had a toxic staggered dose	Reflections received from staff - demonstrates learning Refreshed learning with qualified staff regarding PGD	No further lessons identified	Closed
GHC69119	01/05/2024	01/05/2024	10:00	Charlton Lane Hospital	Charlton Lane-Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Pharmacy	Sodium valproate	Yes	400 mg	400 mg	Oral	Oral	Patient is on Sodium Valproate on a covert care plan, Pharmacy dispensed 200mg Sodium Valproate gastro-resistive, it was clearly specified on the medication box and label to not crush and take as whole tablet. It is unclear how much of this medication the patient has taken.	Dr's aware and to be discussed in MDT, physical observation regularly obtained with no deterioration evident. At present time, no evidence of harm caused to patient. Concerns have been raised with pharmacy, consultant to liaise with family as part of duty of candour.	Pharmacy informed and patient now has only crushable Valproate in meds drawer	NA	Closed
GHC69127	01/05/2024	01/05/2024	08:00	Cirencester & Fairfrd Hospital	Ciren Hosp- Coln Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Administration	Oxycodone	Yes	5mg	5 mf longtec	Oral	Oral	I noticed that the shortec had been administered according to patient record, but in paper CD book the Longtec had been signed out.[Both drugs are called Oxycodone 5mg]	Informed the sister.	action learning set completed on the ward with the registered nurses involved who administered the medication incorrectly,	the staff were administering the medication dose which it should be as in the longtec druyg. the staff did not alert the doctor to prescribe the correct drug on the drug chart	Closed
GHC69130	01/05/2024	13/03/2024	09:40	ICT	ICT Glos Asp & Stbridge DN	Nursing / residential home	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong patient	Stock balance recording errors / discrepancies	Levomepromazine	No					Stock checking medication for our patient. During check noticed that the wrong patients medication had been stock checked onto the stock sheets. Discussing this with care lead. Just in case medications for patients are kept in a bag and both bags with individual Just in case medications had been labelled with the same patient name, Patient names are similar causing the error.	With the care lead, we went through all Just in case and ensured there were in the correct bag and labelled with the correct patient name. Stock check completed	Visiting Nurse gave advice regarding safe storage and recording of medication. Advised to store individuals medication in appropriately labelled containers.	No lessons to be learnt - Residential Home staff require to be more vigilante with medication storage and recording especially when patients names are similar or the same. Clear labelling and checking with two persons required.	Closed
GHC69179	02/05/2024	01/05/2024	09:00	Cirencester & Fairfrd Hospital	Ciren Hosp- Coln Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Prescribing	Oxycodone	Yes	5 mg longtec	5 mg shortec	Oral	Oral	noticed that the oxycodone prescribed for a patient should have been prescribed as LONGTEC , it was prescribed as SHORTEC BD	reported to the dr and this was then ammended to LONGTEC BD	dr changed prescription to the correct dose and drug	dr has reflected on the error and aware of reviewing and checking prescriptions	Closed
GHC69181	02/05/2024	02/05/2024	09:00	ICT	ICT Glos North South DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Insulin glargine	Yes	12 units	10 units	Subcutaneous	Subcutaneous	Insulin dose was increased by 2 units on the incorrect day. Drug chart that was written wasn't very clear on the amount of days to leave in between each increase. The chart looked as though it said to increase every 2 days but it says to increase every 7 days. A few errors on the chart and unclear information.	I have emailed the GP a picture of the current chart and asked for it to be rewritten with clearer instruction. Also asked to specify what the parameters are for the patient as it states 2 different parameters on the front of the chart.	- S1 records reviewed. - Medication chart viewed. - Checked action taken and new chart now in place.	- Medication charts to be checked before taking to patients homes. - This chart had a few few things crossed out and was not clear.	Closed
GHC69201	02/05/2024	29/04/2024	13:30	ICT	Reablement Gloucester	Care agencies (home care)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Prednisolone	No					Medication issues: carers had been issuing medication from old dossette box pre-admission instead of new one. Old medication still in flat- carers been issuing discontinued medication. Box medication from discharge not taken: a 5 and 7 day course of antibiotics and steroid causing break in treatment cycle. Care agency using app to administer medication so unable to see what patient has been taken: care agency unable to provide these details and also unable to take advice of what needs to be taken from matron - they reported can only take the changes from pharmacist. This also caused difficulties as pt cannot remember what medication has been taken and if has taken it that day.	Visit booked with community matron to review. Community matron bagged up old medication no longer used for sister to remove from property. Matron phoned pharmacy to update chart for care agency.	All appropriate actions taken	Awareness of care agency limits with online systems for medication - added to issue log	Closed
GHC69250	03/05/2024	14/02/2024	12:00	MH Specialist Services	Early Intervention Team GRiP	Other organisation (please specify)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Medication breakages / spoilage	Preparation by administering clinician(s)	Paliperidone	No					Administering Paliperidone 75mg injection into patient. Plastic syringe near top where needle is attached was broken, meaning liquid leaked out of syringe and was not admninistered into patient	administration stopped explained and apologised to patient discussed with Consultant re: ensuring patient had medication adminstered somehow liaised with pharmacy MHRA Yellow Card submitted since			Awaiting Review
GHC69262	03/05/2024	20/04/2024	10:00	Forest of Dean Hospital	FoD Hosp-Woodland View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Prescribing	Propranolol	Yes	40mg three times daily	40mg once daily	Oral		incorrect dose on prescription of Propranolol Patient prescribed Propranolol 40mg three times per day rather than the correct discharge dose of 40mg once per day. Prescription screened by pharmacist and continued. Patient transferred to Forest of Dean Community Hospital 25/4/24 Error not identified until 3/5/24 when medical team asked to review low blood pressure event	Not identified until 3/5/24 when reviewed for low BP - reviewed by ACP at Forest community Hospital where error was identified when reviewing patient following hypotensive episode and noted medication list from acute hospital and discharge summary. patient also reviewed by GP on the ward and medication reviewed and amended to more appropriate dose and frequency	reviewed by ACP at Forest community Hospital where error was identified when reviewing patient following hypotensive episode and noted medication list from acute hospital and discharge summary. patient also reviewed by GP on the ward and medication reviewed and amended to more appropriate dose and frequency. dosage had not been questioned by nurses as this was not an unusual dosage for anxiety of which the patient suffered from	prescription to be checked against discharge summary by all parties including pharmacy and nursing staff	Closed
GHC69296	04/05/2024	29/04/2024	08:30	The Vale Hospital	Vale Hosp- Peak View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Prescribing	Clopidogrel	No					Patient admitted to ward and clerked by GP ON 28/4/24. During morning drug round on 29/4/24 nurse noticed that patient was prescribed abasaglar insulin and clopidogrel. Patient said that she does not have the insulin. Nurse asked patient about the clopidogrel and patient said she was not on that medication.	Patient did not have insulin in bedside locker which alerted nurse to check if prescription was correct. Nurse had a look at patient's chart from acute trust and patient was not prescribed clopidogrel and insulin. Nurse looked through discharge summary and discontinued medication and both of these medication were stopped. Both medication were omitted and Dr was tasked to review.	This has been discussed with the doctor involved. Training has been offered and reflection has taken place. Ward was busy and drug chart from transferring ward not clear in instruction. staff have been encouraged to continue to check medications for new patients and raise discrepancies if noted.	Doctors need time to concentrate on clerking patients to avoid mistakes being made. Staff to continue to discuss medication with patient and relatives to identify any discrepancies.	Closed
GHC69351	06/05/2024	02/05/2024	09:00	ICT	ICT Chelt St Paul's DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Other (unlisted)	No					Planned visit for insulin administration and pessary administration. On administration of pessary, the applicator would not release the medication. Attempted x3 and unsuccessful	Duty of candour - Apologised to patient and explained unable to administer due to equipment Datix completed New script was sent by pharmacy the day before so asked Carer to collect as there would be a new applicator in the box Patient reported no dryness / irritation so no further action taken at time of visit - Planned visit on Sunday for pessary administration Drug chart signed and coded	Incident appropriately handled by member of staff Duty of candour followed Onward appointment arranged and new equipment ordered	N/a	Closed
GHC69357	06/05/2024	06/05/2024	09:45	Cirencester & Fairfrd Hospital	Ciren Hosp- Coln Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong patient	Monitoring / follow-up of medicine use	Topiramate	No					Medication sent home with the wrong patient. One patient being discharged home and the other going to an internal transfer, both medications went with the patient being discharged home. There were 2 bags of medication on the side on the nurses station and the nurse took one bag and ward clerk took the other bag as she thought it had been forgotten. When patient arrived home family called to say they had the other medication and ward clerk went to collect.	Apologised to family and ward clerk collected.	the ward clerk took the ttas thinking she as helping the nurse discharging the patinet, the nurse did not check the 2nd packet that is had the incorrect name,	the discharging nurse is aware of the importance of checking the ttas and all the requirements for discharge	Closed
GHC69362	06/05/2024	02/05/2024	17:00	ICT	ICT Cotswold North DN	GP	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug has expired	Pharmacy	Hydroxocobalamin	No					whilst visiting patient for administration of b12 injection, noted that the drug went out of date 4/24 and it was 2/5/24 so unable to give this. It was dispensed from the chemist on the 1/5/24 so was out of date when issued	did not give drug and requested another dose	No action required Reporter checked medication correctly prior to administration and identified medication had been dispensed out of date GP surgery were informed and will undertake own assessment of event	Continued vigilance with checks when undertaking medication administration	Closed
GHC69397	07/05/2024	05/05/2024	10:30	ICT	ICT Cotswold North DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Levomepromazine	No					I visited patient on Sunday 5th May with a new starter colleague to perform drainage of Abdominal Ascites and replenish Syringe Driver, for a patient who is Palliative and requiring Symptom control. I did the Syringe Driver, talking the new starter through how to do it. Patients wife reported he had needed 2 doses of extra Oramorph for breakthrough pain during the last 24 hours, and Paracetamol too, and asked if we could increase the Morphine in the driver. We discussed this and I agreed to increase from 25mg to 30mg today and we would review again tomorrow and could increase more then if still needed, Patient and wife happy with this. I drew up the Morphine and the Midazolam, the water for injection and the new starter checked it with me. I set up driver, checked site and commenced driver at 10.30. I then went on to perform the drainage procedure, again talking the new starter through how to do it. We chatted to the patient to assess how they were and checked Heels and Bottom which were intact. We were running behind time and went b	As soon as I realised what had happened, I rang ES B6 and reported it to her, I asked if she wanted us to go back and redo the S/D, ES asked if we had time to do that, we would need to give away one of our remaining visits to enable us to do so, ES said she would prefer us to continue with our visits in Tewkesbury and she would ask the nurse on the Late shift who was going over to Newent to visit this patient and redo S/D. I offered to ring Patient and wife and explain what have happened and apologise and ES said yes please. I did this and both patient and Wife thanked me for explaining and were satisfied with plan to rectify. I then rang the nurse on the Late shift and explained and asked if she would visit to redo S/D, she said yes that was fine. I was unable to complete this datix at the time as we still had 2 long visits to do, we finished out shift an hour late and I told ES I needed to go home and would complete at home. I tried later on Sunday evening and again yesterday morning but was unable to login to S1 at home	Review of notes Thankyou for your candour and honesty with this patients care. He came to no harm As a team we must always ensure the drug charts we use are legible for all to see and use and will take this learning back to the team.	Confirmed no harm came to patient no further learnings noted	Closed
GHC69408	07/05/2024	13/04/2024	06:55	Crisis Resolution Home Treatmt	CRHT Cots & Vale	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Administration	Promethazine hydrochloride	Yes	50mg		Intramuscular		Patient in location Maxwell Suite required RT IM - accidentally administered using blunt drawing up needle	Constant review of patient following RT	Staff involved offered supervision following event - recognises that the mistake happened as a result of chaotic environment. Staff ensured patient was monitored following incident to ensure they were not in any pain etc Staff reminded to ensure where possible that two qualified nurses oversee drawing up of RT to minimise any errors	None	Closed
GHC69448	08/05/2024	06/05/2024	17:00	ICT	ICT Stroud BerkeleyVale DN	Nursing / residential home	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Drug has expired	Storage	Other (unlisted)	No					Patient with Type 2 Diabetes was discharged to own home from care home around lunchtime on Bank holiday Monday. CN visited as scheduled the same day to administer insulin dose at 5pm. Patient had been sent home without community insulin drug charts for the prescribed BD insulins. It was documented on SystemOne that an attempt had been made by a GHC CN to request these drug charts from the patient's temporary GP on the Friday prior to the weekend but that the wrong GP was listed on SystemOne so they had rejected this request. The same CN had informed the care home staff on the same day that the patient could not be discharged home without these drug charts. In addition, both pens of one of the insulins she was sent home with were out of date (opened more than 28 days ago, according to the handwritten labels). Regarding the second insulin, the cartridges she was sent home with were in date but there was no cartridge pen with which to administer them.		Discussed with reporting nurse their concerns. Main concerns were 1. out of date insulin, 2. Lack of drug chart on a bank holiday weekend 3. Using vials of insulin with needle syringe. Call to discharging home who agreed this was poor practice to let a patient home without having a drug chart, out of date insulin and no means to give the insulin. The manager will pass on this information with the discharging nurse for learning. There was also some confusion in the patients notes of who the patient 's registered GP was, this was one of the main reasons why the drug chart never materialised.	Check patients correct GP before requesting drug chart. Check what the patient is coming out with including insulin supplies and how they are being administered. (added to clinical governance agenda, to discuss triage and to prevent from happening again).	Closed
GHC69456	08/05/2024	08/05/2024	10:00	Intravenous Therapy Team	IV Therapy Services	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Information / advice to patient not given / wrong	Information / advice to patients	Piperacillin + Tazobactam	No					Pt planned for discharged Tues 7/5/24 to commence Iv Tazocin elastomeric device Weds 8/5/24. Contacted pt, who was not aware of need to have Iv Abx but was discharged with Midline insitu, not aware of DN referral for line care. No discharge summary available on EPR, No documentation of discharge plan. Contacted ward 2B, discussed with Discharging nurse and ward Co-coordinator, line left in situ, not sure of Dn referral made, not for IV Abx but was not communicated to IV Therapy to stop order of Elastomeric devices. 7 Devices delivered 7/5/24	IVTT staff communicated with patient and ward staff. Drugs wastage.	VTT staff communicated with patient and ward staff. Drugs wasted.	IVTT are currently trialing an alternative fresh filled 24hr elastomeric pump which will minimise drug wastage.	Closed
GHC69505	09/05/2024	08/05/2024	06:17	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Prescribing	Codeine	Yes	15mg		Oral		Patient reported to be in pain. Pain seems to be intense after mobilising to toilet. Patient does have regular ibuprofen and Paracetamol , which has max out on. Duty Dr was informed prescribed codeine phosphate 15 -30 tablets [Controlled Drug]Four Times Daily instead of 15mg to 30mg Four Times Daily. Administering staff signed 15 tablet given to patient.	Patient informed. Spoke to patient about medication she had in earlier hours of the morning. Patient was able to remember she had 1 tablet of codeine. patient reported it was one tiny tablet. Reassurance given to patient. Administering staff to clarify dose given to patient. Doctor informed. Management team informed NEWS score 0	Nurse completed new meds competency and reflection which demonstrates learning. Consultant following up with medic involved to reflect on error.	No further lessons identified.	Closed
GHC69506	09/05/2024	03/05/2024	14:30	Stroud Hospital	Stroud Hosp-Endoscopy	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong method of preparation	Preparation by administering clinician(s)	Fentanyl	Yes	50 mcg Fentaly	50 mcg Fentanyl and Buscopan 20mg	Intravenous	Intravenous	While preparing for the procedure, I was in the room supervising a new member of staff, there were 3 other qualified person int he room, one is preparing the medication, one of the qualified have had noticed the preparing nurse was struggling, and she offered to help but apparently declined.So she went and reported to me and said that" I think you may need to check on the other staff as she seems to be struggling, went and check the preparing staff asked her if shes OK, She replied" I don't know it seems like the medication I'm trying to withdraw has spilled all over so the dose is short with 1 ml, so i have taken another ampule and have the student check it with me. I let her finished what shes doing and said to her that we will talk about that later, and then i went back to supervised the other nurse. So, she handed the medication tray to the consultant, the medication was administered by consultant, at this point the other nurse who highlighted the issue earlier, went to me again to say that there was a discrepancies with the medic	As soon as i was told about the first incident, i went and check with the preparing nurse, to see if shes OK, she said that she has spilled some of the medication she was trying to withdraw, so she took another ampule and get the student to check,i did noticed that the tray was wet. I told her to finished what shes doing and try to slow down, and try to get rid of other tray that she don't need to avoid getting confuse.Told her we will talk about this incident later. With the second incident about the error in labelling, as soon as it was recognised, both consultant and the preparing nurse rechecked again and agreed that correct medication and dose was given its just the label that is wrong. The preparing nurse was given a few minutes time out. All staff was debriefed about the incident was told to reflect about it. They been reminded about the Trust policy on drug administration especially the 5 rights . Senior Sister was informed	Spoke with the nurse concerned. She admitted she was struggling to concentrate, possibly due to tiredness and it was unlike her. She confided that she was suffering form menopausal symptoms and that this could be cause of her lack on concentration. She acknowledged her mistake and will ask for help. Reminded of the policy and related SOPs	Self awareness. Re visited the medicines administration policy, including Controlled drugs. All staff need to complete the Safe Administration of Medicines e-learning.	Closed
GHC69547	09/05/2024	09/05/2024	20:20	Cirencester & Fairfrd Hospital	Ciren Hosp- Coln Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Controlled stationary (medication related)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Stock balance recording errors / discrepancies	Oxycodone	No					Whilst doing the medication round at 2000hrs we realised that there had been an error made in the balance of one of the controlled drugs in the CD book. On page 50 Longtec 5mg had 28+12 = 50	Balance corrected Datix completed	the book has been reviewed, this was a miscalculation when the new packs were delivered	simple maths mistake,	Closed
GHC69556	10/05/2024	10/05/2024	00:50	North Cotswolds Hospital & GMC	NC Hosp-Cotswold View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Morphine	Yes	10mg	2.5mg-5mg	Oral	Oral	I incorrectly administered 10mg of oramorph instead of 5mg which is the maximum dose the patient is prescribed.	Monitored patient for adverse side effects	On review of this incident the error has been identified in a timely manor. The patient had been accurately monitored for any adverse side effects of this incident. Ward Doctor informed of the incident for review. No harm noted as a result of this error.	On review of this incident there is no obvious contributing factors that could increase risk of error. The error was identified and escalated after it had taken place. Correct documentation was completed. Colleague involved in this incident has reflected on the incident.	Closed
GHC69558	10/05/2024	08/05/2024	09:00	ICT	ICT Stroud Cotswolds DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Medication breakages / spoilage	Preparation by administering clinician(s)	Insulin glargine	Yes	30units		Subcutaneous		Insulin administration. Attached the safety needle to the pen device, when attempting to prime the needle the pen became stiff and 'jammed' not allowing me to prime/administer that insulin. The home care leader was informed and a new pen was selected to administer the insulin dose.	Informed Nurse Lead of Stroud ICT and care lead of the care home. Discarded the faulty pen and safely administered insulin with a new correctly working pen - explained and apologised to patient.	Action already taken and affected pen has been returned to manufacturer for investigation. Datix links to 69364. Staff member acted appropriately by not using pen and reporting incident. pens with same batch number have been removed from use and new stock ordered.	Nil- being investigated by manufacturer.	Closed
GHC69566	10/05/2024	21/04/2024	09:30	LD Inpatients - Berkeley House	LD Inpatients - Berkeley House	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Medication storage issue	Storage	Atomoxetine	Yes	80mg		Oral		Temperature of clinic room over 25 degrees on at least 8 occasions in the last 11 days	Reported and fixing of air conditioning unit underway. Pharmacy aware	Incident dealt with appropriately at time of incident.	Discussed in team meeting, all issues regarding medication fridge temperatures to be escalated to nurse in charge and pharmacy.	Closed
GHC69575	10/05/2024	10/05/2024	12:00	Sexual Health Service	Sexual Health Integrated ISH	Pharmacy-provider	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Ordering, collection or delivery	Estradiol	No					Prescription written on 3/5/24 scanned to Fairview Health Pharmacy for delivery back to Milsom Street Clinic the following week (10/5/24). Patient arrived for appointment and the prescription had not arrived.	I made contact with Fairview Health Pharmacy, the prescription had been dispensed and was still at Fairview Health. I made contact with the patient, apologised that medication was not at Milsom Street clinic for her appointment today, offered for her to collect from Fairview Health or Milsom Street. The patient stated she has taken the day off work and could we find out why this had happened. I informed her that we would follow this up with our pharmacy provider. Patient will collect medication next week from Milsom, copy of prescription sent to me which indicated delivery to Milsom.	Fairview Pharmacy will complete own investigation	Fairview Pharmacy will complete own investigation	Closed
GHC69586	10/05/2024	09/05/2024	12:30	Rapid Response & EONS	Rapid Response	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Information / advice to patients	Prednisolone	Yes	60mg prednisolone	30 mg prednisolone	Oral	Oral	RR practitioner attended patient's property for review. Patient stated that she had taken her regular medication in her dosette box but not her antibiotics or her steroids as she was unsure which to take. I again asked patient if she had definitely not taken them and she replied no. she stated she had no carers that visited, just her daughter who visited every afternoon. Patient then took 30mg prednisolone and her antibiotic doxycycline, amoxicillin was removed from the property as had been changed to the doxycycline. 10 minutes later a carer arrived and advised me she had given the patient 30mg prednisolone that morning, so patient had received a total of 60mg rather than the prescribed 30mg daily.	Observations were recorded. Carer was advised not to give any prednisolone the next morning due to increased dose that day, also advised of steroid toxicity warning signs to look out for. BNF checked and max daily dose is 60mg, so dose not exceeding this. Patient advised of the medication error. I also called her daughter and informed her of the medication error, she was under the impression that she was giving the patient her antibiotics and steroids when she visited in the afternoon. I clarified with patient, her daughter and carer that carer was to give prednisolone with morning medications and the patient's daughter would give doxy at her afternoon visit as no box and carers unable to administer. Aware to hold prednisolone the following day.	All necessary actions taken at time of incident	None	Closed
GHC69617	11/05/2024	11/05/2024	09:00	Montpellier Secure Inpatients	Montpellier Low Secure Unit	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Clonazepam	Yes	1mg		Oral		Patient was given his medication which he put in his mouth and was given a cup of water which he drank before the staff left. Shortly after another patient found the cup with a tablet in it. This was presented to patient if this was his, patient took the cup with medication and took the medication		Staff to be vigilant when administering medication	None	Closed
GHC69648	12/05/2024	12/05/2024	09:00	ICT	ICT Forest North DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Ordering, collection or delivery	Insulin human	Yes	18 units insttead of the 30 units	as above	Subcutaneous	Subcutaneous	Routine visit to check patients blood glucose level and insulin administration. Arrived at property to find patient only had 18 units on his insulin pen-patients dose was 30 units. No more pens available in the property.Patient informed me that he had a delivery from the pharmacy on the friday but did not include his insulin. Unsure if this was due to fact not ordered by Dn's or not put through by GP.	Shift lead and Band 7 contacted and asked for advice. They advised for me to contact OOH GP to get another prescription. OOH contacted - new script written and sent to chemist that is available and open on a sunday. This chemist was in Gloucester. Patient has no family or friends so cleared with Band 7 that I was then able to go and collect the medication. OOH GP also confirmed that they wanted the rest of the insulin dose administered to make the 30 units when medication in property. Patient revisited and insulin given. Datix completed.	Correct actions taken No harm to patient	- Discussion to be had at team time regarding the reordering of supplies in a timely manner - No further learning identified	Closed
GHC69824	15/05/2024	15/05/2024	10:00	North Cotswolds Hospital & GMC	NC Hosp-Cotswold View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Fentanyl	Yes	12 mcg/hr	12 mcg/hr	Topical	Topical	It was noticed that patient has had 2 fentanyl patches 12mcg/hr on her left shoulder.According to the notes,a new patch was applied yesterday.Staff were on duty yesterday reported they removed one patch from her right shoulder.Unsure if patient has had two fentanyl patches on admission. Patient admitted on 13th may 2024.	Removed the older fentanyl patch dated 10th from left shoulder back .Apologised to the patient. There is no signs of adverse reaction. Informed doctor. Observation remains stable,NEWS 0.	On review of this incident it was highlighted that the patient was wearing X2 Fentanyl Patches 12mcg/ hour and she should have only been wearing one. There had been a patch change under the care of the ward and through speaking with nursing staff involved there had been one patch removed at time of last change. There is no documentation to support a transdermal patch record of application and or removal. Possibility that patient was transferred with X2 Fentanyl patches in situ as verbally one had been removed however this cannot be confirmed.	As a result of this incident the patient did not come to any harm. Medically reviewed and patient had appropriate apology. What can be learnt is that the Transdermal patch care plan was not completed at time of the patch change. This will be feedback to the nursing staff via safety brief update to ensure that this patient and all subsequent patient's have the appropriate care plan that should be checked daily.	Closed
GHC69900	16/05/2024	16/05/2024	15:05	ICT	ICT Chelt Town Centre DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Glycopyrronium bromide	No					During stock check for syringe pump today, noticed 5x ampoules of Glycopyrronium missing. Last stock checked on 18th April and 5x ampoules reported as being present. 5x ampoules were issued with pharmacy label dated 15/05/2024. So should be total of 10 ampoules but 5x are missing.	Datix completed.	Situation to be monitored. family to research property. no obvious concerns regarding history of drug use. if further concerns action to be taken.	Importance of regular stock check for medications in patient home environment.	Closed
GHC69985	18/05/2024	18/05/2024	15:00	ICT	ICT Chelt Peripheral DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Missing medication	Stock balance recording errors / discrepancies	Dalteparin	Yes	18,000units	This is the correct dose.	Subcutaneous	Subcutaneous	Patient is on daily fragmin 18,000 units - stock sheet signed stated there were 18 in total stock yesterday - on arrival there were only 17 fragmins in the property.	Discussed with band 7 on duty - advised to give todays fragmin and arrange for a nurse to take in a lock box this evening and lock away medication.	Appropriate actions taken at time of incident. Nurse and family member searched the property for the missing injection. Patient did not know why there was any medication missing. Patient known alcoholic and has memory issues. Locked box taken out the same day and Fragmin medication put into the locked box and explained why to the patient.	N/A	Closed
GHC70011	19/05/2024	19/05/2024	12:36	Wotton Lawn Hospital	Wotton Lawn-Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Dopamine	No					Patient who is informal failed to return from home leave for his medication as planned.	Staff contacted him and he stated he would not return. Crisis Team contacted Duty doctor and on call manager both informed and ward advised accordingly	staff followed process by contacted CHRTT and making a plan Barry to be discharged with follow up	N/A	Closed

GHC70015	19/05/2024	09/04/2024	08:00	Stroud Hospital	Stroud Hosp- Cashes Green Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Lidocaine	Yes	5% medicated plasters		Topical		I removed a medication patch at 08:00 and re-applied a medication patch straight away. I had signed for removal and assumed a new one was due to be applied, however instructions show application was 20:00.	This was then removed at 20:00 by another Nurse and omitted.	Nurse made aware of error by colleague. Nurse reflected on error - and has learnt from incident. Actions following identification appropriate - Dr aware and reviewed, and changed prescription to make application note clearer, in order to reduce the risk of this happening again. No harm caused.	Carefully read prescription notes - note amended to make this clearer. Learning from incident shared to team.	Closed
GHC70047	20/05/2024	20/05/2024	09:30	Wotton Lawn Hospital	Wotton Lawn- Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Use / possession of over-the-counter (OTC) medicine	Co-codamol	Yes	8mg/500mg	8mg/500mg	Oral	Oral	During medication round, Nurse approached patient to give medication, which was accepted and taken by patient. Nurse later found a box of 8mg/500mg Co-Codamol tablets in her room. Patient stated they were not aware where they had come from, however later divulged that her spouse had brought them onto the ward on Saturday (18/5/24). The box states that there should be 32 tablets in the box, however there are only 3 strips of 8 tablets in the box, with 14 missing from the strips. Patient says that she has been taking these since Saturday when husband brought them in.	Medication removed from patient. Medication handed to NiC to inspect. Duty Dr made aware, who advised that they would update ward medics to attend for review after MDT. Attempted to take a set of physical observations however patient had taken leave.	Medics reviewed Ward Manager to speak to husband and remind that bringing medication in is prohibited.	Husband brought medication in for patient	Closed
GHC70066	20/05/2024	14/05/2024	10:13	CYPS/PH Public Health Nursing	CYPS/PH- Immunisation Team	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong drug / medicine / item	Administration	Other (unlisted)	No					on completion of the DTP/Men ACWY vaccination session at Chelt Ladies college. It was noted that a DTP was given to a young person who only had consent for a MEN ACWY vaccine. It was unsure at the session whether this was an error in vaccination or error in documentation. However on return to base it was identified that the vaccine count supported that it was a vaccine error, due to the count showing extra an DTP was given and a MEN ACWY was not.	On discovery it was brought to the attention of the management team, a conversation was held with the Head of service. the plan was for the school nurse to be contacted and discussions on how to contact the parents. Also to offer the Men ACWY as the young person was not given the Men ACWY as consented. Incident recorded in RiO notes retrospectively	Following the incident the school were informed of the incident who in turn informed the parent as the student was a boarder Parent contacted the service and requested a written explanation as to how the error occurred and this process was supported by PALs Parent informed that young person was not protected against MenACWY as the wrong vaccinated been administered and option for the team to revisit or for the school to provide the vaccine was offered,parent chose school . incident shared with the team and need to ensure that SOP followed by the team revisited. contributing factor to incident was that practitioner did not have separate vaccines in separate trays. Whilst form was clearly marked that the young person did not require DTP the practitioner did not check the vial prior to administration. Practitioner wrote reflection and also competencies revisited.	Need to follow SOP vaccines to be in separate trays. introduction of e consent would highlight error at time of vaccination as batch number entered would have highlighted error where a large number of students require only one vaccine to have 1 nurse to vaccinate these thus only 1 tray of vaccines on table and risk reduced	Closed
GHC70084	20/05/2024	20/05/2024	17:45	ICT	ICT Chelt St Paul's DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Insulin human	No					patient self administered insulin when they removed pen from body insulin could be seen in the needle safety cap	patient advised to monitor BGL later in evening, If BGL running high to drink plenty of clear fluid and to call 111 if feels unwell	All appropriate actions taken by reporting clinician & BGL 11.5mml/l this morning 21/5/24 within her normal range & so no ill effects following last nights visit.	All actions completed and appropriate advise given to patient	Closed
GHC70098	21/05/2024	19/03/2024	14:30	ICT	ICT Chelt Peripheral DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Stock balance recording errors / discrepancies	Dalteparin	No					On arrival to administer daily fragmin injection, I had pre-checked the MARS chart to ensure that it correctly matched the prescription on the drug chart. I could see that the stock count hadn't been correctly recorded and that the date hadn't been recorded either. I am aware that this a MARS chart, but in terms of correct documentation the chart hasn't been filled out correctly.	Photo taken, datix completed, hopefully some reinforcement of correct documentation.	- Discussion to be had with team regarding the importance of completing the MAR charts correctly	- Staff to make sure they are completing MAR charts correctly - Discussion to be had at team time	Closed
GHC70104	21/05/2024	21/05/2024	09:00	Charlton Lane Hospital	Charlton Lane- Chestnut Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Drug administration omitted / delayed	Administration	Lorazepam	No					Whilst making bed for the patient by the staff in her room, staff found 6 tablets at the side corner of the patient bed by the wall and some on the floor. Tablets found on the scene are 2 forceveal capsule,1 thiamine tablet,1 vit B strong tablet,1 lorazepam tablet,1 sertraline tab.	Staff took all the medications found and discard it as indicated Informed Jr Dr 1:1 with the patient on why, when, how did the incident happen. Specific answer cannot be given by the patient and continuously said that she cannot swallow it because of her implants.	Plan in place to ensure patient takes one tablet at a time and is fully observed to have swallowed then. Husband informed and said she did this at home.	Notice in clinic room to advise all staff of the above.	Closed
GHC70128	21/05/2024	20/05/2024	12:15	ICT	ICT Chelt Peripheral DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Stock balance recording errors / discrepancies	Buprenorphine	Yes	10 Micrograms/hour	Yes	Other	Other	Patient had new delivery of morphine patches, which comes in boxes of 4. 1 box delivered to home - HCA documented incorrect amount of morphine patches on stock sheet in patients home, stated there was 5 in total however only 4.	Informed an RN of this and marked the error on stock sheet. Double checked GP prescribed 4 not 5, which was correct.	-Discussion to be had with member of staff who made mistake - Team will be reminded in team time to be careful when stock checking controlled medications	- staff to be reminded to be careful when stock checking medications	Closed
GHC70132	21/05/2024	21/05/2024	09:00	ICT	ICT Glos Inner City DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Fentanyl	No					Arrived to change fentanyl patch and noticed drug chart had not been completed since 12/05/24. Patch has been prescribed for change every 72 hours. Checking laptop and patients notes and it appears no follow up appts booked after 12/05/24 to change the pain patch.	Apologised to patient. Changed the patch and completed drug chart. Spoke with SCN and informed her what had happened.	Review of notes, Care plan in place for patch change every 72 hours however not highlighted on appointment exactly dates of change. Human error the patch was not changed every 72 hours. Discussion with GP and patch changed to weekly change and reduced dose from 25mcg to 5mcg. Regraded to no harm due to patient was not in pain when patch was not renewed.	Appointment should be clearly written so staff visiting are aware when patch needs to be changed.	Closed
GHC70135	21/05/2024	21/05/2024	15:15	Wotton Lawn Hospital	Wotton Lawn- Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Information / advice to patient not given / wrong	Use / possession of over-the-counter (OTC) medicine	Paracetamol	No					patient was searched upon return to the ward following being seen at the garage. staff found patient had a pack of 16 paracetamol. stated that they had not taken any - this was confirmed by the packet being untouched	medication removed. escorted leave only for foreseeable	Managed well by staff with a plan in place	N/A	Closed
GHC70173	22/05/2024	22/05/2024	09:00	Charlton Lane Hospital	Charlton Lane- Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Medication storage issue	Storage	Codeine	Yes	Unsure		Oral	Oral	Codeine phosphate 15mg was found in patients bedroom, they are not prescribed this medication. They have been on home leave therefore may have accessed this medication at home and brought it back to the ward.	Medication was taken from the patient and kept in the clinic safe keeping.	Appropriate to remove medication. Not clearly documented if discussion was had with patient to explain expectations - patient since discharged so unable to followup	Staff to explain expectations and to document this conversation.	Closed
GHC70182	22/05/2024	18/05/2024	18:00	ICT	Reablement Forest	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Lisinopril	No					I regret to report that unfortunately on evening 20/05/24 I noticed that I made an error with medications on the 18/05/24 PM call. I missed a Lisinoprol 5mg bedtime dose, it was down to human error. I had correctly done the other bedtime medications but did not register that one when I was working through the MAR chart. I explained my error to the patient on this call 20/05, and asked if he has been feeling unwell since my mistake. He advised thankfully that he has been feeling ok. He did attend a routine GP appt today, they advised BP low but has been this way since recent admission before HF/Reablement started. I call OOH after leaving to advise them. They asked me to go back and fill in MAR chart for the 18/05/24 and to put code M and initial. Upon retuning I was able to with johns consent explain to daughter Jacqui what has happened and I advised I have made OOH aware. They understand that it was human error, and that I have taken the correct steps to report it. Jacqui is away now from tomorrow until Saturday. Neighbour Lynne Ed	I explained my error to the patient on this call 20/05, and asked if he has been feeling unwell since my mistake. He advised thankfully that he has been feeling well. He did attend a routine GP appt today, they advised BP low but has been this way since recent admission before HF/Reablement started. I call OOH after leaving to advise them. They asked me to go back and fill in MAR chart for the 18/05/24 and to put code M and initial. Upon retuning I was able to with patient's consent explain to daughter what has happened and I advised that I had made OOH aware. They understand that it was human error, and that I have taken the correct steps to report it.	Correct procedure taken at time of incident	Staff member realised error and took correct course of action.	Closed
GHC70196	22/05/2024	25/04/2024	18:00	Charlton Lane Hospital	Charlton Lane- Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Senna	No					During the April Missed Dose Audit, a missed dose was identified during the 18:00 medication round.	Staff bank have been contacted to request a reflection from the nurse.	Reflection provided by bank nurse - issues raised with staffbank to followup due to quality of reflection	no further lessons identified	Closed
GHC70263	23/05/2024	16/05/2024	12:00	Charlton Lane Hospital	Charlton Lane- Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong method of preparation	Administration	Vortioxetine	Yes	5mg		Oral		Medication given covertly despite pharmacy plan not in place to advice correct way to give covertly. Other medication already being given covertly has a plan. Noted to have occurred again on 21/05/24 by same nurse. All other doses either given overtly or declined by patient.	Pharmacy chased to complete covert plan. Nursing team reminded of need to check covert plan to ensure giving medication correctly. Informed bank office for as administering nurse was bank.	Reflection provided by bank nurse - issues raised with staffbank who are following up with individual	No further lessons identified.	Closed
GHC70269	23/05/2024	23/05/2024	12:00	Charlton Lane Hospital	Charlton Lane- Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Paracetamol	Yes	1 tablet at 8 am and 2 tablets at 12 pm		Oral		Regular paracetamol (500 - 1000 milligram) signed as "1" (8:20 am) and "2" milligrams (12:51 pm) instead.	Discussed with charge nurse, agreed agency nurse that signed the medication meant to indicate amount of tablets given rather than dosage. Datix in place	Reflection received from agency nurse.	No further lessons identified	Closed
GHC70323	24/05/2024	23/05/2024	18:00	Montpellier Secure Inpatients	Montpellier Low Secure Unit	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Zuclopenthixol	No					Depot injection not administered- error not noted until 24/05/24	Once error noted depot administered appprox. 12 hours delay	Reminders for depots have been added to the handover sheet	None	Closed
GHC70383	26/05/2024	26/05/2024	13:15	ICT	ICT Stroud SevernHealth DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Other (unlisted)	No					Colleague noted that only 6 ampoules of metaclopramide in the property yesterday when documented that its 7. Daughter is able to give stat doses therefore wait to review until today if stat dose had been given as daughter out yesterday. Daughter present today. Both patient and daughter report stat dose not administered since syringe driver has been commenced.	Stock sheets reviewed. Searched box of drugs to check ampoule has not fallen out of box. Datix completed.	I have reviewed the S1 and paper records relating to this case. It seems that the patient's daughter may have made an error in using GHC documentation. In future, we must ensure that everyone using these processes has received and understood training in the use of our documentation.	See above. In this instance, no harm came to the patient, their family of GHC staff.	Closed
GHC70403	27/05/2024	27/05/2024	04:25	Wotton Lawn Hospital	Wotton Lawn- Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing controlled stationary	Controlled stationary							Staff was doing Sunday Controlled check. It was noted that Espranor oral lyophilisate Tablets was noted on the CD as 23 in total number . On the checks by the 2 staff who were auditing the CD could only find 22 in total number for the CD medication, 1 was missing in number.	-CD Register was updated and corrected, the current number of tablets is 22 in total number for Espranor oral lyophilisate 2mg. -The following Datix was done.	X2 nurses recounted and all medication there. None missing.	incorrect counting of medication	Closed
GHC70421	27/05/2024	22/05/2024	12:45	ICT	ICT Cotswold South 1 DN	Other organisation (please specify)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Morphine	No					Visited patient to carry out initial assessments. Patient has only been home from hospice for a short time. She had some JIC medications in the home already, in a box on top of her cupboard, but also had some which she had recently had collected and brought to the home. Checked existing stock whilst signing in new and one amp of morphine sulfate 10mg/ml and one amp of midazolam 10mg/2ml missing. Patients respect form, and pages of her drug chart for stat dose administration also missing. Patient and prospect carers seem to have an idea that patient took this medication with paramedics, and took the paperwork to the hospice with her.	Rewrote respect form with patients old one - she agreed that all to remain the same please. Have asked GP for another drug chart please. Not needed at this time but needs to be in the home.	Reviewed notes Community Drug chart uploaded to notes from prospect hospital - show stat dose of midazolam and morphine have been administered - likely to be reason for missing stock	Good use of datix and stock checking medication	Closed
GHC70460	28/05/2024	28/05/2024	08:00	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Insulin glargine	No					Arrived at pts home to perform daily BGL and insulin. Pt informed me that no one had arrived the previous day (27.05.24) to administer her insulin. Pt called friend who came to administer insulin.	Apologised to pt for this error Informed RC Datix Made sure had appointments going forward advised pt to call into the RC in future if no one arrives.	Correct action taken by visiting nurse. Referral centre informed. Apology given to the patient. Future appointments checked.	Patient has learning difficulties and correctly contacted her friend. patient now advised to call the DN's if she is worried that a nurse is not visiting. To be discussed in team Time and nurses to be encoraged to check future appointments carefully.	Closed
GHC70496	28/05/2024	28/05/2024	11:06	Charlton Lane Hospital	Charlton Lane- Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Lorazepam	Yes	0.5MG		Oral		Early shift nurse handed over that she gave PRN Lorazepam 0.5mg to patient A. However Late shift staff realised that it was charted as RT not as PRN medication in the medication chart. Informed the senior nurse in charge. Patient observation completed.	Informed nurse in charge. Patient observation completed	Has since been corrected and marked as PRN	NA	Closed
GHC70543	29/05/2024	29/05/2024	09:00	Later Life	Later Life North	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Zuclopenthixol decanoate	No					While getting pts depot injection (Zuclopenthixol 500mg) out of the drug cupboard. It was noted that the stock of said medication was incorrect. There should have been 11 amps, but there was 10. On further investigation it was noted that there was a discrepancy with another dose (Zuclopenthixol 200mg) The stock sheet said that there was 10 amps in the cupboard, but there was 17. There was 2 pt NHS Numbers entries on the stock sheet which should have reduced the no to 15. This discrepancies was check by 2 trained nurses.	The discrepancies were reported to the acting team manager and the stock sheets were amended to reflect the amps that were in the cupboard by the trained nurses.			Awaiting Review
GHC70586	30/05/2024	30/05/2024	10:40	MIIUs	MIIU- Stroud Hosp	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Medication storage issue	Storage	Flucloxacillin	No					Day 11 Room temperature in clean Utility Maximum temperature is >25 degrees. TTO & stock Medication is already being short dated & used within 3/12 In-going issue due to unresolved issue with Air handling & temperatures in unit. GHC Estates are due to visit today as escalated last week that Air handling unit is still nor being effective in Clean Utility following works to adjust it as part of Capital Defects work following unit refurbishment in 2022	short date drugs escalation to SD via issues / datix	escalated to SD who in turn is following up air con options issues log identifies problem	air con needs to be in place to ensure this does not reoccur	Closed
GHC70598	30/05/2024	18/05/2024	18:30	Rapid Response & EONS	Rapid Response	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Ordering, collection or delivery	Other (unlisted)	No					RRP arrived at a ladies home address to deliver medication, this lady was not on the RR caseload and wasn't expecting this. She contacted her pharmacy on the following Tuesday to be advised that this wasn't for her. Patient did not accept the medication delivered, letter of complaint written to GP surgery	Medication delivered to correct address.	Practitioner concerned spoken to and statement of events attached to Datix. advice given to member of staff regarding searching patients within S1. GP surgery updated.	Ensure correct patient selected on S1	Closed
GHC70621	31/05/2024	24/04/2024	12:00	Charlton Lane Hospital	Charlton Lane- Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Other (unlisted)	No					The patient was not given his prescribed epimax cream.	This was discovered in a missed dose audit for that particular month. The member of staff will be notified via the trust staff bank, and a request will be made the medication nurse to complete a reflection.	Managed in line with missed dose policy	NA	Closed
GHC70624	31/05/2024	24/04/2024	08:00	Charlton Lane Hospital	Charlton Lane- Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Other (unlisted)	No					The patient was not given his prescribed epimax cream.	This was discovered in a missed dose audit for that particular month. The member of staff will be notified via the trust staff bank, and a request will be made the medication nurse to complete a reflection.	Managed appropriately in line with falls policy	NA	Closed
GHC70626	31/05/2024	17/04/2024	08:00	Charlton Lane Hospital	Charlton Lane- Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Other (unlisted)	No					The patient was not given his prescribed epimax cream.	This was discovered in a missed dose audit for that particular month. The member of staff will be notified via the trust staff bank, and a request will be made the medication nurse to complete a reflection.	Managed in line with missed dose policy	NA	Closed
GHC70627	31/05/2024	30/05/2024	12:00	Forest of Dean Hospital	FoD Hosp- Woodland View Ward	Other organisation (please specify)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Pharmacy	Midazolam	No					CD - TTO arrived on ward this pm. night nurses put medication away. Also found in CD delivery box, a box of five ampules of Midazolam. Not patient own. No label. Not ward stock. No order book.	Night nurses checked ward stock levels - all correct. Re checked by am nurses. Pharmacy informed. Two phones calls with pharmacy. Pharmacy porter took medication back. Secured in box - tab numbers - A01690109 + A01690108 Ward manager informed.	Night nurses checked ward stock levels and patients own supplies - all correct, unable to contact pharmacy as OOH therefore handed over to day staff to follow up Re checked by am nurses. Pharmacy informed. confirmed their error Pharmacy porter took medication back. Secured in box - tab numbers - A01690109 + A01690108	CD medication to be checked in at time of delivery pharmacy dispensing error - correct action taken by ward staff	Closed
GHC70628	31/05/2024	31/05/2024	10:50	North Cotswolds Hospital & GMC	NC Hosp- Cotswold View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Contra-indication in relation to drugs or conditions	Information / advice to patients	Aspirin	Yes	2-3 tablets		Oral		Staff Nurse was administering morning medication and saw a packet of Disprin on his table. They are a generic disprin and not prescribed by his GP or by the Doctor on the ward. Patient explained that he prefers to take the Disprin rather than Paracetamol and that he takes 2 or 3 when he needs them.	Staff Nurse removed the Disprin, explained to him the risk. Explained that he is prescribed Dalteparin, and that he has been having this in the evening. Explained that they are both anitcoagulant, he is aware of what the effects are for both the medications. He is able to justify that he is taking the Disprin occasionally and that he has been taking it for over 30 years.	On discovery of this incident. Patient was immediately advised of the risks of self-medicating in conjunction for regular prescribed medications. Advised of bleeding risk of taking 900mg of Aspirin and Daltaparin at the same time. Patient demonstrated full capacity to understand risk. Declined for nursing staff to safely store medication in locked pod therefore kept on his person. Doctor informed and reviewed regular medications to limit bleeding risk- Daltaparin stopped. Patient's NOK advised not to bring any more medications in for patient . Nursing staff documenting daily to ask patient what he has taken in the event he could fall.	On review of this incident it highlighted that the incident was picked up and recorded in a timely manor. On further enquiry the drugs were not brought in at time of admission and were brought in by visitor had brought them in during admission. Patient had been concealing them in his bag. Patient appropriately given advice regarding falls and bleeding risk. Has capacity to continue taking medication against nursing advice. Doctor appropriately reviewed. Patient nursed in side room therefore low risk of other patients accessing tablets.	Closed
GHC70632	31/05/2024	17/04/2024	12:00	Charlton Lane Hospital	Charlton Lane- Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Other (unlisted)	No					The patient was not given his prescribed morning dose epimax cream on 22/04/24, 23/04/24 and 23/04/24	This was discovered in a missed dose audit for that particular month. The member of staff will be notified, and a request will be made the medication nurse to complete a reflection.	Managed in line with missed dose policy	NA	Closed
GHC70635	31/05/2024	15/04/2024	08:00	Charlton Lane Hospital	Charlton Lane- Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Other (unlisted)	No					The patient was not given his prescribed morning dose of epimax cream on 15/04/24 and 16/04/24.	This was discovered in a missed dose audit for that particular month. The member of staff will be notified, and a request will be made the medication nurse to complete a reflection.	Managed in line with missed dose policy	NA	Closed
GHC70639	31/05/2024	31/05/2024	06:15	Sexual Health Service	Sexual Health Integrated ISH	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Medication storage issue	Storage	Other (unlisted)	No					Ref GHC70637 Unplanned loss of power to site at 06:15 caused 2 drug fridges to breach temperature. Fridge 1 reached 12.7'C Fridge 2 reached 13.5'C Drugs above 8'C for approx 1hr 20min	Fridges emptied by Pharmacist at earliest opportunity just after 8am Fridge 1 reached 11.5'C Fridge 2 reached 12.0'C Drugs temporarily stored in another non-drug fridge in building until power restored, then returned Immform stock incident report Assessment of suitability for ongoing use made by Pharmacist	Appropriate action taken at time in response to unplanned power interruption. No further action required	No additional learning for staff for this incident	Closed
GHC70665	01/06/2024	01/06/2024	09:00	ICT	ICT Glos HQR DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong / unclear dose or strength	Administration	Insulin glargine	Yes	18 units	16 units	Subcutaneous	Subcutaneous	Visit to residential care home for insulin administration - two patients located on dementia unit both requiring insulin support. Met by care staff doing drug round & handed basket of medication for what I believed was patient A, patient A is a dementia resident bed bound & unable to communicate & confirm identity, chart checked against medication same name noted on medication & insulin pen, same batch & expiry, chart for 18 units of Abasaglar therefore 18 units administered. On returning to care assistant to commence patient B insulin she advised me I had wrong tray & that was for patient B : a second dementia all care patient who is bed bound & cannot communicate. Advised carer I had administered 18 units rather than the prescribed 16 units patient A has on her own chart.	Band 6 in referral informed & SCN of rosebank team also informed of error, advised staff to closely monitor & to increase oral intake today of carbs & to provide foods that will keep sugar slightly higher today & to escalate to 999/111 as appropriate. Band 7 Made aware. Plan to support Care home with a team member monitoring and supporting home to prevent further incidents	Care home have been advised to support visiting staff with patient identification to prevent further incidents. Plan moving forward for regular nurse contact to support within the home	Discussed widely with team to ensure a carer attends all insulin visits within home. Policy for medication management to be reviewed by all visiting staff	Closed
GHC70676	01/06/2024	01/06/2024	11:00	ICT	ICT Chelt Management	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Information / advice to patient not given / wrong	Monitoring / follow-up of medicine use	Morphine	Yes	2.5mg	yes	Subcutaneous	Subcutaneous	Morphine not entered correctly on the stock chart following a stat dose administration. 10 Morphine sulfate ampoules entered on stock chart to be the remaining stock instead of 16.There had been 17 remaining and patient had been given a stat dose and therefore one used and 16 ampoules should have been the remaining stock. Also water for injection had run out completely and there had been no mention of water for injection to be brought to the patient. Luckily carried spares otherwise this would have caused a delay in the replenishment of the S/Driver leading to end of dose symptoms which could have caused family distress.	Drug calculation corrected- No drugs missing, only a miscalculation error and not checking the essential Items to be brought in for the next visit. Triaging band 6 informed as this happened during the out of hours visit.	All appropriate action taken	N/A	Closed
GHC70686	01/06/2024	01/06/2024	22:30	Wotton Lawn Hospital	Wotton Lawn- Dean Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Temazepam	No					Myself and RMN HS WENT TO DISPENSE C/D TEMAZEPAM TO FOR PATIENT. ON COUNTING 1 TABLET LESS THAN RECORDED.	CD CUPBOARD EMPTIED AND SEARCHED, CLINIC SURFACES AND FLOOR SEARCHED - NIL FOUND. ENTRY MADE IN CD BOOK. CONTENTS OF BOX AND CD RECORD PHOTOGRAPHED.	Incident reviewed and information in Datix is incorrect. No medication incident occurred Staff confused by storage and dispensing of Temazepam Training currently being rolled out to Registered staff	Staff require further training regarding CDs	Closed
GHC70693	02/06/2024	02/06/2024	02:00	District Nursing (ENDS)	ENDNS- Out of Hours DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Drug has expired	Administration	Midazolam	Yes	5mg	5mg	Subcutaneous	Subcutaneous	Visited to administer stat meds for symptom control. I discovered that during previous visit y colleague midazolam had been given that had expired. All midazolam ampoules were out of date (05/2024). This had not been picked up at stock check on 31/05/24 by day DN or by ENDNS nurse who gave the medication on 02/06/2024.	Family aware and explained I could not administer this medication due to it being out of date. Advised it was only 2 days past expiry but that I would ensure I reported this incident to get it investigated for future learning and to prevent this happening in the future. Family understanding about this matter. More medication ordered through OOHGP.	CNL supported review of the datix and further discussions with the member of staff and supervised practice and reflective writing completed and medicines management completed . Head of professional aware of incident and development for staff member.	Staff member supported to ensuring safe administration of medicines and follow the necessary checks.	Closed
GHC70706	02/06/2024	02/06/2024	08:15	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Other (unlisted)	Yes	64	62	Subcutaneous	Subcutaneous	On documenting administration of insulin, noticed that for the last 4 days, the wrong dose is written as being administered. Unknown if patient has received the correct dose or not. Patient is prescribed 62 units of Lantus, paper documentation states 64 units was administered for last 4 days. No recent dose change. Documented on SystmOne as being 62 units administered.	Apologised to the patient that he may have received the wrong dose however patient is well and has had no adverse side effects. Advised I would report the error. Blood sugars have been high over the last couple of days and was fine today. Photograph taken of chart	Notes reviewed and think this was a documentation error . All 3 staff emailed to inform them of this and to be very careful in he future with ensuring the correct doses are documented.	Important to raise these concerns to ensure we can improve our practice and try and reduce mistakes happening again.	Closed

GHC70732	02/06/2024	02/06/2024	19:50	ICT	ICT Cotswold South 2 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Drug administration omitted / delayed	Administration	Insulin glargine	No					Diabetic nurse increased insulin to 16 units, advised DNs via RC on 23/5. RC nurse (myself) updated care plan and amended appointment ledger but amended wrong appt, I amended it via appointments tab in S1 but accidentally amended the same day 23/4 and therefore visit had already taken place and nurse may not have seen it. I should have amended 24/5. Insulin dose increase was therefore not actioned by team.	- Datix completed. - Appointment tomorrow amended to reflect need for new chart to be collected and insulin dose increase to be actioned. - New care plan was written 23/5. - Email and apologies will be sent to diabetic team and await further instruction from them. - I will visit patient when I am back from leave to apply duty of candour and offer apologies.	Reviewed notes - minimal harm to patient, delay in medication dosage change notes. Specialist nurse aware and is not concerned all necessary actions completed once - delay in increase noted	Nurses has reflected on process and will ensure dose increase is added to correct appointment in the future	Closed
GHC70745	03/06/2024	25/05/2024	17:30	Long Term Conditions	Heart Failure	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Contra-indication in relation to drugs or conditions	Prescribing	Ramipril	Yes	25/05/24		Oral		Patient was discharged from Cardiology on Ramipril and Sacubitril/Valsartan	I noticed this on review of discharge summary and telephone call with patient on the 28th May. Advised patient to stop Ramipril. Lead Nurse cardiology emailed to highlight within GRH	GRH informed to review practice	Pharmacist at GRH informed.	Closed
										Contra-indication in relation to drugs or conditions	Prescribing	Sacubitril + Valsartan	Yes	24/26mg BD		Oral						
GHC70825	04/06/2024	04/06/2024	12:00	Sexual Health Service	Sexual Health Preg Adv PAS	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Information / advice to patient not given / wrong	Information / advice to patients	Ethinylestradiol + Levonorgestrel	No					I saw a patient in clinic today who wanted to start contraception following a TOP. We discussed the different types available & the patient decided they wanted to start COCP as she felt this would suit her better, we discussed her PMH, for which there was very little, took her BP, height & weight, all these were within the normal limits & it appeared as per UKMEC it was fine to commence COCP. I explained this to the doctor who was working in clinic, who prescribed the COCP, which I then issued & the patient went home with it. After clinic the doctor checked the patients note & had noted that the patient was a smoker, something which I had missed on the dynamic form. As per UKMEC this & her age are a contraindication to COCP due to the risk of CVD.	I telephone the patient & explained that it wouldn't be safe for her to start COCP on the 6th June as previously told in clinic, due to her being a smoker & combined with her age, the risk of CVD. The patient stated that she was an occasional smoker & had stopped since becoming pregnant, but wasn't sure if she would start up again. However, I advised the patient that a different method of contraception would be much safer for her due to her history of smoking and that she had only recently stopped, I advised her to make an appt with her practice nurse to arrange this, I also told the patient to take the COCP to her local pharmacy who will dispose of it for her as she lives outside of the county, so is unable to return the medication to HH. I documented this in the patients notes & will do a reflection on this to use as a learning episode to avoid any further mistakes such as this.	discussions with staff and ensure appropriate training and ability for staff to seek advice.	importance of details at assessment on smoking habits, continued update of training at PLT and discussion at 1-1 and appraisal. Prescribing doctor to prompt staff of criteria.	Closed
GHC70841	04/06/2024	03/06/2024	08:11	PICU	Wotton Lawn-Greyfriars PICU	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Clozapine	Yes	150mg		Oral		On 03/06/24, an agency nurse administered Clozapine without completing the patients physical observations beforehand. On 03/06/24, a bank nurse administered Clozapine without completing the patients physical observations beforehand. On 04/06/24, an agency nurse administered Clozapine without completing the patients physical observations beforehand.		Manager of staff bank informed to contact the members of staff and request for them to follow the POMPAM guidance on medication administration.	The importance of following the Clozapine guidance on administration.	Closed
GHC70842	04/06/2024	30/05/2024	14:00	Long Term Conditions	Cardiac Rehabilitation Service	Pharmacy-community	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Supply issue	Pharmacy	Sacubitril + Valsartan	No					Patient attended clinic (30/06/24). Patient reported she ran out of Sacubitril/Valsartan (Enteresto) 24/26mg 10 days ago. Despite speaking to a pharmacy on 2 or 3 occasions she had not been able to get hold of any Enteresto. Pharmacy reported that they had plenty of the higher dose of Enteresto suggested that patient could perhaps have this dose and cut it in half but this would have to be agreed by the GP or she could see her GP for an alternative. Daughter or patient called the GP surgery to discuss 29/05/24 but hadn't heard anything back so called GP again 30/05/24.	I spoke to the heart failure (HF) nurse for advise 30/05/24, HF nurse gave me a number (on a piece of paper) and suggested the pharmacist to call number to discuss supply. Daughter gave this piece of paper to the pharmacist. Pharmacist would not call the number as said she had already gone through AHH. Daughter then went to another pharmacy who said they were at their quota but would try to order Enteresto. Order placed 30/05/24 but Enteresto did not come in on 31/05/24. Pharmacy however had 14 tablets of Enteresto and were happy to issue this amount while they were waiting for new stock to come in. Daughter(nurse) was a little reluctant for her mum to re start Enteresto if there were going to be issues with supply in the future. I contacted another HF nurse for advice. HF nurse emailed Novartis to ask if there were any supply issues-Novartis reported- no issues. Pharmacist spent one and a half hours trying to secure a supply of Enteresto-	All actions taken by the clinician. Details of incident shared with the Heart Failure service lead.	Incident to be shared with the team and insight into pharmacy stock limitations shared.	Closed
GHC70913	05/06/2024	05/06/2024	14:00	ICT	ICT Chelt Peripheral DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Information / advice to patient not given / wrong	Monitoring / follow-up of medicine use	Insulin glargine	Yes	24 units	yes	Subcutaneous		Nurse from Overton Park GP practice called to speak to a lead nurse. They had noticed in the patient's documentation for insulin dose was incorrect. The nurse had recently increased the insulin dose and drug chart was written and DN took this into the home. Systm one notes show different dose not relating to the increased dose.	I asked the person who went in today if there was only one drug chart in the property. They report there was only one chart as they remembered taking the old chart out of the home. They then returned to the property to check and took photo of the front and inside of the drug chart Line manager informed. Updated the Practice nurse at the GP surgery To discuss at Team Time to ensure notes on S1 are accurate.	After discussion with senior nurse it was thought that staff have been copying and pasting the insulin doses in the system one notes. Paper documents checked and correct dose has been given according to drug chart however, notes on system one do not correlate.	Lesson to take to team time to discuss accurate record keeping	Closed
GHC70930	05/06/2024	05/06/2024	18:00	The Vale Hospital	Vale Hosp- Peak View Ward	Other NHS Trust (please specify)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Prescribing	Enoxaparin	No					Patient transferred from Southmead Hospital today with paper drug chart. Enoxaparin 40mg subcutaenous injection for 18.00pm not signed for by preceeding doctor.	- Staff nurse called out of hours doctor to request for prescription to be written up for tonight's dose so that patient can be administered it. - Out of hours doctor called ward back and prescribed Enoxaparin 40mg subcutanous dose via email prescription. Patient given medication tonight at 20.10pm. Therefore did not miss dose or treatment.	Incident reviewed. Staff are correct to check that paper drug charts from other hospital trusts are written correctly and legally. Patient received medication and did not miss a dose.	If out of hours unable to assist then patient would have been clerked by ward doctor the following morning. Staff continue to ask transferring ward to ensure correct medication charts are sent with patient and this does not always happen. Staff should continue to check for legality of drug charts for new patients in particular.	Closed
GHC70940	06/06/2024	06/06/2024	06:10	The Vale Hospital	Vale Hosp- Peak View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Hyoscine butylbromide	Yes	10mg	5mg	Oral		Buscopan 10mg administered instead of 5mg (half of the tablet) in error.	Patient informed of error and I apologised for this mistake. The effect potential effects of this overdose explained to patient and asked to highlight any concerns/changes in sensation etc. Also informed that doctor would be informed and incident form completed. Ward doctor tasked to highlight error.	Incident reviewed and contacted nurse involved. She has reflected on the incident and has made changes to her practice as a result of this. She will be checking the dose as well as the medication prescribed to ensure that the correct dose is given.	The early morning drug round is busy and often combines other clinical care to meet the needs of the patient. Nurses have been reminded to wear the red tabards when dispensing medications and colleagues have been asked to avoid interrupting a medication round.	Closed
GHC70950	06/06/2024	01/06/2024	06:00	CYPS/PH Community Specialist	CYPS/PH-Children Complex Care	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong / unclear dose or strength	Administration	Clobazam	Yes	0.75 millilitres	1.5 millilitres	NG/PEG/PEJ		Medication administration record written incorrectly for clobozam (used for eplileptic seizures) dosage, copied from previous month's medication administration record rather than checking medication bottles again for the month of June. Previous dosage 0.75millilitres (ml), new dosage 1.5ml. The dosage amount had changed as the new medication bottle had a different strength per millilitre. Wrong dose given of clobozam (0.75ml) as consequence of the above and not checking the bottle label correctly - this is a daily medication, so the incorrect dosage was given at 6am by multiple staff members for at least 3 shifts, as error discovered in the morning of 05/06/2024 whilst on shift. The bottle with the new dose of 1.5ml was approximately 2/3 used morning of 01/06/24. Bottle is approximately 150ml in volume (writing datix from	Error discovered on 05/06/2024. Correct dosage of 1.5millilitres given at 6am for morning medications during this shift. Care team made aware of the discrepancy. Datix completed on 06/06/2024 as well as a phone call with manager.	A trial of second checking medication administration record against the medication bottles to be started immediately to reduce the risk of medication errors. This to then be rolled out throughout the team All team members to be reminded of the importance of checking the medications against the bottles. All team to be reminded that MAR is a record of administration NOT a prescription to follow New training has been completed by all staff	A trial of second checking medication administration record against the medication bottles to be started immediately to reduce the risk of medication errors. This to then be rolled out throughout the team All team members to be reminded of the importance of checking the medications against the bottles. All team to be reminded that MAR is a record of administration NOT a prescription to follow	Closed
GHC70966	06/06/2024	05/06/2024	14:10	Stroud Hospital	Stroud Hosp-Cashes Green Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Administration	Colecalciferol	Yes	1000 units		Oral		Patient was given Colecalciferol tablet 1000 units instead of CO-amoxiclav 625mg by the student nurse who I was supervising. I was interupted by a care assistant at that time.	Informed patient of the drug error. Apologised to patient. Doctor has been tasked to review the patient.	Student has reflected on medication error. Incident has been discussed between student, Senior Sister, PEF, and University representative. Ward sister to work with student to achieve medicines management competency.	As a first year student, discussed realistic goals/achievements for placement. Student to focus on lunchtime medication rounds. Fewer medications/patients, with increased focus. Also implementation of red tabards- to warn against interrupting medication rounds.	Closed
GHC71029	08/06/2024	06/06/2024	19:15	Crisis Resolution Home Treatmt	CRHT Cots & Vale	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Ordering, collection or delivery	Lofepramine	No					patient given 7 days worth of wrong medication. Medication was prescribed to the patient, however, this was stopped and an alternative antidepressant prescribed	patient called the team office and situation rectified the following day.	Staff member given clinical supervision with TACP	None	Closed
GHC71037	08/06/2024	08/06/2024	08:00	North Cotswolds Hospital & GMC	NC Hosp-Cotswold View Ward	Other organisation (please specify)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Pharmacy	Lamotrigine	No					SN went to administer Lamotrigine from pod. New box from fairview in pod, on outside of box, patient label states 14 lamotrigine 25mg tabs, take one daily at 8am. Inside box is a strip of 50mg tablets.	SN administer correct does of medication. Phone call to fairview to inform them. No drug error in administering. Dispensing error from pharmacy.	On review of this incident the error was correctly and promptly identified before the administration error took place. Escalated with supplying pharmacist who will be dealing and escalating the error internally as the drugs were checked by X2 separate people.	Promptly recognised by nursing staff. Error avoided. Medications taken out of use and escalated with relevant pharmacist. Uploaded photograph of the medication on attachments.	Closed
GHC71038	08/06/2024	08/06/2024	11:40	Wotton Lawn Hospital	Wotton Lawn-Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Use / possession of over-the-counter (OTC) medicine	Paracetamol	Yes	~46		Oral		Possession of medications : Staff went to prompt ADLs at 11:40 however patient was found with the following medications in a hand bag which she left open on her bed.. -Found two boxes of panadol that contains 24 tablets in that only 12 tablet left. -One empty box of paracetamol that contains 24 tablets and 2 empty boxes of paracetamol of 16 tablets. -One salamol inhaler which her mum brought in. -She was asked from where she got the medications to which she said she don"t know initially however later informed Dr that she purchased it from Tesco. She informed staff that she has being taking these medications for		Patient bloods at A&E came back all within range, no treatment required. All leave now escorted no unescorted	Patient purchased medication whilst on leave WM need to understand how the medication got in via patient as all patients searched on UE leave	Closed
GHC71065	09/06/2024	09/06/2024	08:00	PICU	Wotton Lawn-Greyfriars PICU	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administered when stopped	Administration	Sodium valproate	No					I was about to give a patient their 8 AM medication which included (Sodium Valproate Controlled Release) when I discovered that the Sodium Valproate which was being administered was not the same with what was written on the patient's chart on Rio. The patient was being administered with Sodium Valproate gastro resistant which had been discontinued.	I withheld the medication and sort clarification from Band 6 who was in charge at that time. They advised me to seek clarification with the duty doctor. The duty doctor also advised me to seek clarification from the Pharmacist on call. The pharmacist advised me to come to the pharmacy in order to get the right medication which I did. Eventually the patient was administered with correct medication.	Help sought from senior members of the team to ensure the right medication is being administered.	Ensure that medication charts are read properly, down to the finer detail, to ensure that the right medication is being administered.	Closed
GHC71069	09/06/2024	02/06/2024	02:30	Rapid Response & EONS	Rapid Response	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Gentamicin	Yes	140mg		Intravenous	Intravenous	Gentamicin prescribed by hospital for pt & 2nd dose administered on the 2/6 by Rapid Response Practitioner. Visiting pt next night for 3rd dose patient stated to me she was surprised at how quickly the dose had been given the night before & as a push not in a bag of fluid. Patient said dose given so quickly it was over before she knew it & as she had had the same drug previously she thought this wasnt right. Guidelines state dose should be given over one hour in a bag of 100mls Nacl.	Details noted, patient not compromised & incident raised with my line manager when next back in	Practitioner spoken to Gentamicin now removed from RR formulary as no longer able to support administration route.	All staff to check Medusa regularly and prior to administering medication.	Closed
GHC71071	09/06/2024	02/06/2024	10:30	Rapid Response & EONS	Rapid Response	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Gentamicin	Yes	220mg		Intravenous	Intravenous	IV Gentamicin administered to a patient, patient was visited overnight for repeat bloods where patients son stated that the dose the previous day before had been given over 10 mins & the dose after that given over 30mins, this is not the correct timing & should be over one hour.	Pt not compromised, treatment continued & issue raised with line manager when next at work	Practitioner spoken to, Gentamicin now removed from RR formulary as RR can no longer support administration route	Staff to ensure Medusa is checked regularly and prior to administration of drugs.	Closed
GHC71072	09/06/2024	28/05/2024	08:00	Stroud Hospital	Stroud Hosp-Cashes Green Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Senna	Yes	7.5mg	7.5mg	Oral	Oral	When doing the medication round in the morning I was working with a student nurse. Senna was due for a patient at 22:00, however it was administered at 08:00.	This drug error was recognised by the night staff that evening when the drug had already been administered. No harm caused to patient.	Student has reflected on medication error. Incident has been discussed between student, Senior Sister, PEF, and University representative. Ward sister to work with student to achieve medicines management competency.	As a first year student, discussed realistic goals/achievements for placement. Student to focus on lunchtime medication rounds. Fewer medications/patients. Also implementation of red tabards- to warn against interrupting medication rounds.	Closed
GHC71079	09/06/2024	08/06/2024	22:00	Charlton Lane Hospital	Charlton Lane-Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Other (unlisted)	No					NIC of night shift found that 10 patients medications, prescribed during the late shift (either 18:00 to 19:59 or 20:00 to 23:59, or both) had not been marked on the electronic chart as being administered.	The Nurse in charge of the night shift contacted the medication nurse for the late shift over the phone. The medication nurse said that she has given all medications and updated everything. An e-mail regarding this incident will be sent to necessary Trust colleagues	Managed appropriately Meds were reported to have been given so no meds error	NA	Closed
GHC71118	10/06/2024	10/06/2024	10:30	Wotton Lawn Hospital	Wotton Lawn-Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Pharmacy	Estradiol	No					Medication administration as per regime on EPR systems. During administration, it was noted that Estradiol gel had not been dispensed and therefore there was no stock in the clinic. Phoned pharmacy to chase order as order had been made over the weekend. According to pharmacy, a prescription error had occurred which meant that the gel could not be sent to the ward. Therefore, the gel was not given.	Explained the medication omission to the patient, NiC and WM. Followed up with pharmacy to understand the next steps for aquiring Estradiol gel.	WM spoke with medics around error and px apology was given to patient	Medics incorrect px which caused delay	Closed
GHC71122	10/06/2024	10/06/2024	10:30	Wotton Lawn Hospital	Wotton Lawn-Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Pharmacy	Hydrocortisone	No					During administration of prescribed drugs as per EPR system, it was noted that Hydrocortisone 2.5% ointment was not available to administer. We explained this to the patient, who accepted this and was aware that the medication was currently on order. We later phoned pharmacy to let them know regarding the Hydrocortisone cream and they expressed that due to a prescribing error, it was not ordered. This had been known by the ward doctors who were fixing the issue.	Explained to patient the issue and apologised for this. Chased issue with pharmacy to ensure next steps are taken. Ward doctors are aware.	Managed well by nurses	px error- medics aware	Closed
GHC71146	10/06/2024	04/06/2024	17:45	ICT	ICT Chelt St Paul's DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Preparation by administering clinician(s)	Dalteparin	No					Notes From GP Arnt Clear Last Entry 31st Which Advise To Ignore The Drug Chart To Continue Unitl INR 2.0 But That Hes Happy To Take Nursing Advise Of 2.5. But Has Started Pt Back On The Warfarin, But For Repeat INR Tommorow Being The 01st June, But No IRN Recorded On System. Felt Uncomfrotable With This And Decided To Seek Advised From Late Lead, Lara Agrees Instruction For Administation Isnt Clear- And Wouldnt Feel Confident In Administering Herself And There For Advises To Admit Dose Today,- Chart Signed As E- Other Reason and To See System One. But On Review Of Chart, No Signature For Administration Of Fragmin Yesterday, Although System One Records Looks Like It Was Administered. Advised To Make Note On Ledger For Lead To Review And Find Out What Plan Is For Patient And May Need To Complete DATIX Tomorrow Depending On Outcome.	Late Shift Lead Informed Of Situation, Medication Admitted- Patient Informed That He Wont Be Having It Tonight Note Made On System One For Review Tomorrow. Request To Complete Datix On 05th June- However Unable To Complete Due To Time, Time Blocked Of 10/06 To Allow Datix To Be Completed.	GP drug errors noted. delay in treatment for patient as a result.	Importance of learning from incidents being county wide and of an MDT approach.	Closed
GHC71228	12/06/2024	28/05/2024	23:59	PICU	Wotton Lawn-Greyfriars PICU	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Clonazepam	No					Staff missed to administer the night medication of a patient. Patient was due for his clonazepam and clozapine from 20:00 to 23:59 which was missed.		Staff explored why this medication had not been administered. Nursing staff spoken with around the importance of ensuring patients receive their prescribed medication.	None identified.	Closed
										Drug chart errors - not signed, recording, other	Administration	Clozapine	No									
GHC71305	13/06/2024	13/06/2024	12:51	Charlton Lane Hospital	Charlton Lane-Chestnut Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Paracetamol	Yes	1g	1g	Oral	Oral	Patient did not have sufficient time gap for paracetamol First dose given at 09:04 Second dose given at 12:41 due to Student Nurse and agency nurse did not calculate time gap. Paracetamol given 23 minutes early.	Doctor Informed: Doctor not concerned with no actions Management Informed: Datix & Patient/Family aware Patient made aware, Asked if she would like to call family to report, patient did not want this. Student was supervised by agency nurse who supported her	The patient was discussed with the medics and no treatment prescribed. Both staff have been asked to do reflection and drug review.	all staff reminded to check dosage times especially medication such as paracetamol.	Closed
GHC71327	13/06/2024	13/06/2024	16:30	Wotton Lawn Hospital	Wotton Lawn-Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Use / possession of over-the-counter (OTC) medicine	Paracetamol + Caffeine	No					Service user found in possession of medication in hands when return back to ward after being AWOL. Search completed on return to the ward. Found 3 Panadol soluble tablets in possession. Taken off the tablets from the service user. Enquired whether taken the tablet orally, however declined taking it.	-Room and person search completed. -Taken off the tablet from service user. -A set of observation has been taken. -Informed duty doctor.	Policy and procedure followed	N.A	Closed
GHC71387	14/06/2024	14/06/2024	18:10	Forest of Dean Hospital	FoD Hosp-Woodland View Ward	Pharmacy-community	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong formulation	Pharmacy	Metformin	No					Patient prescribed Metformin MR 500Mgs to be given at 1800hrs. Box in locker dated 22/05/24 noted to say MR on box but medications in box not MR. 5 Tablets missing from strip	Tablets removed from locker. patient has Metformin MR in locker	stock removed , pharmacy informed and addressed locally correct medication dispensed patient received medical review and apology, no ill effects.	investigated by fairview	Closed
GHC71389	14/06/2024	14/06/2024	16:30	Wotton Lawn Hospital	Wotton Lawn-Dean Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Contra-indication in relation to drugs or conditions	Use / possession of over-the-counter (OTC) medicine	Paracetamol	Yes	2 x 500mg	correct	Oral	Oral	Patient informed staff at 16:30 that she had bought paracetamol from the shop whilst on leave and had ingested 2x 500mg tablets.	Patient approached staff and handed medication over. Patient said she needed to purchase due to having headache whilst out. Patient assured staff no other medication was bought.	Prescribed medications reviewed Medics have management plan in place for risk of overdose as this is a long standing issue Risk Paracetamol overdose care planned	Patient engaging with care plan and notifying staff	Closed

GHC71391	14/06/2024	14/03/2024	06:45	Rapid Response & EONS	Rapid Response	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Ceftriaxone	Yes	2g	2g	Intravenous	Intravenous	patient admitted to GRH ED 12/6/24 after 21.00. given iv ceftriaxone 2g at 21.00 by rapid response practitioner. prescription chart and hand over documentation and verbal handover given to SWAST crew and patient conveyed to ED. patient assessed in ED, referred back to rapid response with instructions that iv ceftriaxone given at 06.45am 13/6/24 and they would like rapid response to continue two more doses from 08.30 on 14/6/24 OD. (documented at midday 13/6/24 on tabbed journal by HAT rapid response to re commence ABX am 14/6/24 as already given that days dose). new printed drug chart sent with patient). IV Ceftriaxone is a once a day drug and should be given every 24 hours, this patient received 2 doses within 10 hours.	nil patient was in GRH ED	No further action required	No further action required	Closed
GHC71397	15/06/2024	14/06/2024	22:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Zopiclone	Yes	3.75mg	Yes	Oral		Patient came to clinic and asked for her sleeping tablet. When I checked her dosset box the pot was empty and she said she came and dispensed her medication under supervision at 20:00hrs. She said she was unaware that her medications had changed from 20:00hrs to 22:00hrs as this was done to accommodate Zopiclone time. Unfortunately medications were not signed for that they were given. She managed to sleep well during the night. No handover was given about outstanding Zopiclone. Patient has capacity and is aware of her medications.	I apologised to her and she appeared to have understood and went to her room. I checked on her notes and saw that the one who did medication had written that she came and had her medications. I rang the duty doctor to let him know. I signed the medications for 22:00hrs as other reason not given and wrote a progress note on RIO.	Reflection completed by agency RMN who will also be completing medicines management course with their agency.	No further lessons identified	Closed
										Drug chart errors - not signed, recording, other	Administration	Lorazepam	Yes	0.5mg		Oral						
										Drug chart errors - not signed, recording, other	Administration	Olanzapine	Yes	12.5mg		Oral						
GHC71400	15/06/2024	14/06/2024	15:52	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Paracetamol	Yes	1000mg	1000mg	Oral	Oral	Patient was given does of 1000mg of Paracetamol medication at 14:04 and then at 15:52.	Medication error was discovered on the 15.05.24 morning shift. Set of NEWS were done and duty doctor has been informed.	Agency RMN completed reflection and to complete medicines management course with agency.	No further lessons identified	Closed
GHC71401	15/06/2024	15/06/2024	08:20	Montpellier Secure Inpatients	Montpellier Low Secure Unit	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Levothyroxine	Yes	150mcg	75mcg	Oral		Patient on Stage 1 Self-Administering medication took two doses of 75mcg levothyroxine before the supervising nurse could intervene.	Physical obs taken (NEWS2 scored 1 for pulse of 99), duty doctor informed. Advised to repeat physical obs regularly to monitor and inform duty doctor if there are any changes. Debrief with patient occurred, supervising nurse apologised for not catching the mistake in time. Patient given reassurance, informed of information from duty doctor and advised with plan going forward to monitor.	Patient's personal medication list has been amended- levothyroxine has been separated from the rest of the 08:00 medication	None	Closed
GHC71408	15/06/2024	15/05/2024	09:00	ICT	ICT Cotswold South 2 DN	Other NHS Trust (please specify)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong / unclear dose or strength	Administration	Insulin isophane biphasic human	Yes	18 units	20 units	Subcutaneous	Subcutaneous	Patient discharged from hospital in the evening of 14/06 Patient has frequent admissions for unstable blood sugars and is a high risk patient. Notes state morning insulin dose was increased from 18 units to 20 units and that patient was being sent home with drug chart and d/c summary. Son phoned in on 15/6 to check on DN visits. I was triaging so read patients notes, noted dose increase. Called nurse who was visiting that morning to check they had actioned the new dose. Nurse said they were aware dose was changed but stated no chart was available so they had administered old dose pre-admission of 18 units as per sliding scale.	Nurse had not escalated to shift lead or sought advice before administering dose or before leaving property, also had not documented anything about it. I visited to check property for paperwork, nothing there. Hard to find anything as lots of old paperwork lying around from multiple previous admissions and house is cluttered. Son was present and checked CCTV footage from last night, patient did not appear to have paperwork with them when they came home. I informed son that patient may have been given lower dose this morning due to chart/paperwork not being available and why this was an issue and he was not concerned. TC made to GWH medical expected unit where patient was discharged from, nurse knew patient and informed me she knew dose had changed. Nurse stated she had handed over to night team to send patient home with paperwork but she cannot confirm if this definitely happened. Nurse advised she would need to check notes and call me back to confirm	Reviewed notes - complex Type 1 diabetic with multiple hospital admissions No discharge summary sent with patient - unable to implement new insulin regime over the weekend. OOHs GP advised to continue with previous regime and discuss with GP Monday - treatment delayed, no noticeable effects to patient. Advised line manager of nurse who visited initially to discuss process of escalating to shift lead if medication doses need to be amended and no prescribption is available	Utilise shift lead to support Poor discharge from GWH with no paperwork	Closed
GHC71413	15/06/2024	15/06/2024	08:45	North Cotswolds Hospital & GMC	NC Hosp-Cotswold View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Administration	Metformin	Yes	1000mg	1000mg	Oral	Oral	Identified during the morning medication round that the patient is prescribed Metformin Modified Release tablets 1000mg but in her medication pod there was a box of Metformin 500mg.	Apologised to the patient. Metformin tablets removed from the medication pod. Correct medication ordered from pharmacy. Patient had a new packet of Metformin Modified Release in her medication pod	On review of this incident it cannot be identified whether an error has occurred or whether it was a near miss. To prevent occurrence again the immediate release Metformin were appropriately and promptly removed from patient's own locker. Correct procedure followed when error identified and patient apology given.	This incident will be reviewed with the trained members of staff on the ward regarding errors of immediate release and modified release tablets.	Closed
GHC71436	15/06/2024	15/06/2024	12:30	ICT	ICT Cotswold South 2 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong method of preparation	Preparation by administering clinician(s)	Apomorphine	Yes	50mg/10mls		Other		Joint visit for clinical supervision Nurse sprayed in the eyes with apomorphine medication for injection when expelling air from syringe - deployed pre filled syringe but lifted it off of the syringe causing spraying	Nurse immediately performed eye wash at the kitchen sink Contact made with Britannia apomorphine pump specialists Advised of no harm or escalation process to be followed given exposure to mucous membranes No harm caused	Checked in with staff member no last effect All correct action taken with exposure to medication	Human error Appropriate actions taken	Closed
GHC71473	16/06/2024	16/06/2024	13:30	ICT	ICT Cotswold North DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Insulin glargine	Yes	13 ui	13 ui	Subcutaneous		Visit to administer insulin. Patient had been in hospital yesterday getting checked over for high blood pressure. On return, nurse visited for insulin & BGL check. Visited today for insulin and BGL and noticed insulin not recorded in prescription chart but recorded on S1. Patient advised she had the medication and checked with nurse who visited that forgot to write it in		Discussion with Bank Nurse who omitted documenting insulin administration on paper chart in patient's home address. All documentation clearly written up on S1 patient's records. No harm caused to patient.	Advised to double check insulin charts when administering more than one insulin to a patient. No further learning identified.	Closed
GHC71477	16/06/2024	16/06/2024	15:59	Cirencester & Fairfrd Hospital	Ciren Hosp- Coln Ward	Pharmacy-community	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Ordering, collection or delivery	Fludrocortisone	No					Call from forest hospital to say Fludrocortisone 100microgram tablets have been delivered to them rather than to cirencester hospital. Patient has chronically low bp with a drop	Apologies given to the patient and medication now ordered	medication reordered the next morning as pharmacy closed on the sunday. reported to ward pharmacist to investigate	ward pharmacist to review	Closed
GHC71547	17/06/2024	07/06/2024	13:00	Patient Safety & Learning	Patient Safety Team	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug has expired	Preparation by administering clinician(s)	Medroxyprogesterone	No					Patient double checked expiry date of sayana press injection previously supplied by sexual health prior to administration - found to be out of date May 2024. Patient did not administer and contacted clinic for repeat supply.	Patient did not administer and contacted clinic for repeat.	Correct action taken at the time incident was identified to the service including patient understanding of expiry date checking. Was seen within dosing window of drug and expiry date refers to last date of administration.	To remind all staff of importance of checking expiry date in relation to duration of supply with guidance of using any shorter dated packs first	Closed
GHC71563	18/06/2024	17/06/2024	10:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Prescribing	Folic acid	Yes	5mg	5mg	Oral	Oral	During MDT this morning, it was highlighted by the pharmacist that a patient's medication was incorrectly prescribed. Patient was due to have one dose of 5mg Folic Acid on Saturday, Methotrexate on Sunday, and then another dose of Folic Acid on Monday. Sadly, all 3 medications were prescribed on the same day (Monday).	Staff nurse had noticed the error so did not administer 10mg Folic acid, instead only gave 5mg. Methotrexate was administered as per prescription chart. Drs made aware and have amended the prescription. Pharmacist reassured that this will have caused no harm to the patient.	Issue with prescribing using RiO EPMA effectively. Email sent to clinical systems to highlight issue and for suggested future improvements to system. Not discussed with patient whilst inpatient, care coordinator agreed to discuss with patient on next visit.	No further lessons identified.	Closed
										Wrong time / frequency	Prescribing	Methotrexate	Yes	15mg	15mg	Oral	Oral					
GHC71565	18/06/2024	18/06/2024	08:30	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Use / possession of over-the-counter (OTC) medicine	Paracetamol	No					Patient was not prescribed any paracetamol however staff found a strip of paracetamol from the patients bedroom. Staff removed the medication immediately and enquired him that how did he got this medication. Informed the Duty Doctor.	Removed the medication from the patients bedroom and informed him about the rationale for removing it. Enquired the patient about the source of the medication and whether he had any of the tablet. Informed the Duty Doctor. Advised family that the patients are not allowed to keep any medication in their bedroom.	Incident managed appropriately by nursing team Both patient and carer made aware that medication must be managed by the nursing team.	No further lessons identified	Closed
GHC71588	18/06/2024	17/06/2024	18:00	ICT	Reablement Gloucester	Care agencies (home care)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Paracetamol	No					On visiting Rita 17.4.24 it was noticed that she had not taken medications from her dosette box - afternoon and evening doses from previous day	observations taken - all within normal limits tel call to care agency to ensure prompts with medications on morning call discussion in person with son to ensure he checks and reminds her to take other doses through the day	Correct actions taken at time of incident Not all medication listed - but clearly documented in notes what the patient was prescribed	- Future learning to complete courtesy call to NOK/care agency to ensure compliance of medication. - Ensure all details are added to Datix	Closed
GHC71591	18/06/2024	18/06/2024	15:00	Wotton Lawn Hospital	Wotton Lawn-Abbey Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Information / advice to patient not given / wrong	Use / possession of over-the-counter (OTC) medicine	Promethazine hydrochloride	No					Domestic staff member approached nursing team to inform them they found a partial blister pack in a patients room containing 14 tablets. Blister pack was two rows of seven.	Tablets removed from room.	Items removed from patient, informed of restricted items policy.	Importance of item search emphasised to staff. Patient aware.	Closed
GHC71595	18/06/2024	18/06/2024	10:00	ICT	Reablement Gloucester	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Levetiracetam	Yes	2x 1000mg	2x 1000mg	Oral	Oral	Therapist noted that evening medication had already been taken by patient	Therapist contacted Care Agency who stated that they had noticed this on their visit at 8.00 that morning.	Discussed case with allocated therapist. Advised to discuss accidental overdose with GP and pharmacist and to review with care agency to ensure that he continues to manage. To consider family purchasing a locked box for medication if indicated	To ensure medical advice is sought in a timely way if an accidental overdose is taken. Provided team with backdoor numbers for GPs.	Closed
GHC71605	18/06/2024	18/06/2024	18:30	Stroud Hospital	Stroud Hosp-Endoscopy	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Controlled stationary (medication related)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Fentanyl	No					Was asked by nurses in endoscopy to assist as they were doing a count of the controlled medication and it appears there was a discrepancy found between registered stock and physical stock - they are short 5 ampoules of Fentanyl 20 ampoules were delivered by pharmacy and signed into the book. Total recorded was 55	- Endoscopy nurses had checked numerous times to see if they had counted incorrectly - All orange waste bags were checked from the endoscopy room - staff were unable to check the sharps bin as was already closed - further checks in the controlled drug cabinet performed - Controlled drug ordering book was checked to ensure calculation was correct and not been recorded incorrectly - Endoscopy manager made aware - Band 7 informed via telephone - HSL log sheet completed - Oncall manager made aware - nil advised - Staff reassured -	All appropriate actions taken at the time of discovering the missing ampules, including a thorough search and informing on call manager and the department manager. See attached investigation summery performed by Chief Pharmacist. Conclusion, the missing ampules were inadvertently disposed of.	Thanks you for reporting this incident. Learning points include - -Not to over stock the CD cupboard -Only open 1 box at a time, the rest should remain closed and sealed. -CD were checked twice a day, at the beginning and then at the end of the day, but a running total was not maintained throughout the day -The nurses now ensure they check the total after each use and administration of a CD -Staff were reminded of the Trust's CD administration and storage Policies, including ensuring the keys are never left unattended.	Closed
GHC71619	19/06/2024	18/05/2024	16:46	MIIUs	MIIU- Tewk Hosp	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Prescribing	Other (unlisted)	Yes	PHENAZONE 40mg/g with LIDOCAINE 10mg/g EARDROPS		Per ear		Provision of Otigo to pt which requires a prescriber. Otigo is held within the PGD drugs cupboard. It is a new addition to the formulary. It was assumed that there was not an update to PGDs in the unitor it was difficult to find on the intranet. Otigo information only available on antimicrobial guidelines. No requirement for prescriber listed on this information.	Notice put over Otigo to point out prescription only in drugs cupboard.	Clinician has reflected on this incident to learn and prevent it happening again. Raised at medicines management meeting in June 24 that as a first line treatment a PGD is needed. This will be reviewed.	Clinician has reflected on this incident to learn and prevent it happening again. Raised at medicines management meeting in June 24 that as a first line treatment a PGD is needed. This will be reviewed.	Closed
GHC71678	20/06/2024	13/06/2024	14:00	Long Term Conditions	Heart Failure	GP	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Prescribing	Sacubitril + Valsartan	No					Home visit for patient, checking her medication list and saw that Ramipril 1.25 mg daily was prescribed alongside Entresto 24/26 mg daily. Recent hospital admission at Cirencester Coln ward, where her medications were stopped, I asked for Ramipril to be re introduced once her potassium levels were stable. It seems that her Entresto was restarted again as well. I am not sure where the joint prescription came from.	Called GP surgery they stopped prescribing Ramipril, and I then removed Ramipril from her dossett box. The current box she was taking her medications from only had Entresto in it. So it did not look as though they were taken at the same time.	Called GP surgery they stopped prescribing Ramipril, and I then removed Ramipril from her dossett box.	Recent hospital admission at Cirencester Coln ward, where her medications were stopped, Ramipril to be re introduced once her potassium levels were stable. It seems that her Entresto was restarted again as well. Communication to be clearer	Closed
GHC71701	20/06/2024	19/06/2024	21:00	ICT	ICT Forest South DN	Self-care	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Insulin mixed bovine	Yes	10 units	0 units	Subcutaneous	Subcutaneous	Attended patient on 20/6/24 for routine support with blood glucose monitoring and support with insulin self administration Patient recently discharged from acute hospital with new insulin regime On arrival at patient's house, patient's husband reported that patient's blood glucose reading was "HI" on monitor and stated he didn't think the new insulins regime was working, so he dialled up 10 units of Novomix 30 insulin (which is prescribed to the patient but not for ad hoc administration) and the patient self administered at approx 21.00	I advised the patient and husband that this was not a safe decision to make, and advised them to follow the regime of x2 am insulins as prescribed Blood sugar checked at 08.55 and read at 11.3mmol Contacted CNL nurse for advice Discussed with GP, advised amend insulin doses, chart written as prescribed for tomorrow. GP unconcerned with extra administration of insulin, and to continue as prescribed Patient appeared well in self, reports feels "fine" Patient safety-netted with red flags for hypoglycaemic episodes or deterioration, and to seek medical attention if concerned which they agreed to do	correct actions and advice given at time of incident. Correct information given to husband and not giving additional doses. GP informed. Observations and Blood glucose checked.	for further learning required and all correct procedures followed.	Closed
GHC71703	20/06/2024	20/06/2024	17:15	Charlton Lane Hospital	Charlton Lane-Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong patient	Administration	Apixaban	Yes	5mg	5mg	Oral	Oral	during dinnertime, male patient who was on covert medication plan was given his medication covertly with his meal. he gave it to a fellow patient (Unsure who the patient was). none of the patient remembers who accepted the meal from the male patient. staff were on ward at the time of incident, but was assisting fellow patients who needed support for the dinner.	duty doctor was informed regarding the incident. advised to observe the patients on ward (as unsure which patient had accepted from him). advised to do physical observations to any patients who has a change in presentation. as blood thinners were one of the medications included, continue neuro observations for patients in case if any of the patients had a fall or any injuries.	POPAM competency guidelines sent to all staff and reminded of importance of medication observations To be brought up in the next staff meeting (1st July 2024) Information collated from staff on shift WM/Management team to review staff POPAM competencies	Staff to ensure they are undertaking appropriate medication administration procedures and observation to minimise the risk of further incidents	Closed
										Wrong patient	Administration	Cyproterone	Yes	50mg	50mg	Oral	Oral					
GHC71865	24/06/2024	15/06/2024	13:00	ICT	ICT Cotswold North DN	Nursing / residential home	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong patient	Preparation by administering clinician(s)	Morphine	Yes	Morphine 10mg		Subcutaneous		Nurse visited to replenish syringe pump. Ampoules given by care lead out of locked cupboard or morphine and used in syringe pump. Counted out in stock on nurses chart and care lead book however care manager informed that wrong patients medication was checked out. Same medication & correct dose was administered and was not a drug error. Stock count therefore wrong as missing medication for another resident and extra for patient seen.	Following on from incident, meeting was had with the care home manager, deputy, SCN for care home and SCN from Stow surgery. Reflected on incident and agreed no harm caused. Duty of candour to be had by care home and discussed ways to prevent further incidents. Agreed a zipped pouch with both morphine and midazolam with clear name labelled for each resident and current boxes all look the same and are white blank boxes.	Care leader contact Care Home manager to be made aware of error Community nurse contacted community nursing lead to be made aware of error. No harm came to patient New process by Care Home put in place to ensure each patient's medication in control drug cupboard is kept in separate containers with patient name on to ensure medication is not mixed up. When care leader removing medication out of control drug cupboard for community nurse to check that the name on the medication boxes are correct for the patient .	Human error - Carer leader effectively managed the situation to reduce risk of error occurring again. Error shared against care staff within Care Home Discussion completed in Community nursing team time to remain staff to check name of medication box before administering. Team time documented and shared with whole team including bank nurses for those not present at Team Time on that specific day	Closed
GHC71872	24/06/2024	24/06/2024	21:45	Wotton Lawn Hospital	Wotton Lawn-Abbey Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong patient	Administration	Quetiapine	Yes	150mg		Oral		Routine medication round being completed, medication potted for patient A. Medication given to patient B. Following unclear instructions from administering nurse regarding which patient the medication was for.	Patient informed immediately of the error. Dr updated about event.	Medication error protocol implemented	none	Closed
GHC71901	25/06/2024	25/06/2024	08:00	ICT	Reablement Gloucester	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Administration	Levetiracetam	Yes	2000mg	1500mg	Oral		Patient took the evening medication in the morning	Therapist tried to ring the GP bit closed for training. Therapist discussed the incident with the senior Community Nurse who advised that the patient be given the morning medication at the evening care call. Therapist passed this information to the Care Agency	Reviewed System 1 notes and discussed with therapist. All appropriate actions and advice sought at time of incident. To prevent reoccurence, a locked box is being arranged.	To discuss in governance meeting re gaining an emergency supply of locked boxes to avoid delay in cases where no family or funds to self purchase	Closed
										Wrong drug / medicine / item	Administration	Mirtazapine	Yes	30mg		Oral						
GHC71903	25/06/2024	28/02/2024	14:00	Later Life	Later Life North	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Medication storage issue	Storage	Flupentixol decanoate	No					When I entered the locked clinic room at Avon House I found the medication cupboard door not locked, with the key in the lock. The key safe was also left open	Locked the door and secured the key in the safe			Being Reviewed
GHC71944	26/06/2024	24/06/2024	18:00	Stroud Hospital	Stroud Hosp-Cashes Green Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Drug administration omitted / delayed	Administration	Warfarin	No					S. Patient missed dose of Warfarin B. Mechanical Heart Valve. Ongoing monitoring with INR's A. Informed by nursing staff at handover on 26/6. Warfarin dose had been missed on 24/6. This had been raised with the nurse on duty. They stated that it was missed at not prescribed on electronic system, but on paper chart. ('Warfarin' placeholder appears on electronic chart as a reminder). R. Informed Doctors of missed dose.	Note added to handover sheet to remind of 1800 Warfarin.	patient came to no harm and was closely monitored following this incident. No further doses missed since incident and measures put in place. warfarin is used so rarely that new staff could have never seen the process before and unfortunately the ward is lacking senior staff currently. Now is clearly stated on handover, and added to ward meeting agenda to discuss with team - how can we improve the process? Current process is patient on warfarin is given a 'placeholder' on electronic prescribing system which at the time of the incident stated to check the blue form at bedside (where the it is prescribed, and nurses physically sign). It now states 'daily at 1800'. However if a member of staff used the 'due meds' function to work through medication rounds - this patient had no other medications due to 1800,	patient came to no harm and was closely monitored following this incident. No further doses missed since incident and measures put in place. warfarin is used so rarely that new staff could have never seen the process before and unfortunately the ward is lacking senior staff currently. Now is clearly stated on handover, and added to ward meeting agenda to discuss with team - how can we improve the process? Current process is patient on warfarin is given a 'placeholder' on electronic prescribing system which at the time of the incident stated to check the blue form at bedside (where the it is prescribed, and nurses physically sign). It now states 'daily at 1800'. However if a member of staff used the 'due meds' function to work through medication rounds - this patient had no other medications due to 1800,	Closed
GHC71963	26/06/2024	26/06/2024	10:15	ICT	ICT Glos North South DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Pharmacy	Hydroxychloroquine	No					I visited a patient today for her insulin. We also prompt her morning oral medication. I noted this morning that the 3 remaining blisters in her current dosette tray each had 7 tablets in. The patient has alternate days of 6 and 7 tablets with the Hydroxychloroquine to be taken on alternate days. The new dosette trays provided by the pharmacy appear to be correct but I an unable to say for how long Mrs. Roberts may have been taking the Hydroxychloroquine on a daily basis. The pharmacy have taken the Hydroxychloroquine out of the dosette tray for today and Friday, as we do not know if she had this medication yesterday, but there is no Hydroxychloroquine in the blister for Saturday when a new dosette tray will be started.	Contacted the pharmacy for advice. Spoke to shift lead for advice. Email to GP asking for advice with copy to Band 6 for the area. Followed up email with phone call to ensure surgery had received email.	Thank you for submitting this datix. All appropriate actions were taken at the time of incident including esculation to senior community nurse, GP and pharmacy. Issue resolved on that day by the pharmacy and confirmation received from GP that no harm expected from this incident however blood test completed for confirmation. Discussed with CNL 19/7/24 as to whether any further actions required as has been previous incidents of tablets being in wrong section of dossett box for this patient / pharmacy. Recommended to make contact with pharmacy to inform them incase they want to have any of their own investigations. Unable to make contact via phone. Email sent to alphega@healthera.co.uk Good afternoon, Please could this feedback be forwarded to Hucclecote Pharmacy (7 Glenville Parade, Hucclecote, Gloucester, GL3 3ES, England).	None for DNs - all appropriate actions taken.	Closed
GHC71983	27/06/2024	27/06/2024	09:00	MIIUs	MIIU- Tewk Hosp	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong patient	Administration	Chlorphenamine	Yes	1mg		Oral		Medication error. Wrong pt was administered medication intended for another pt. I went to the waiting area to administer some Chlorphenamine and gave it to the wrong pt by accident. I did not double check the name of the patient and as there were two children in the department and one sat out in the waiting area I gave the chlorphenamine to the wrong child.	When the ENP realized that a mistake had been made several minutes later. I apologised to the Mum of the pt who had had the medication in error, I ascertained that he was not allergic to the medication, that he had not had a dose today and that he was not on any other medication which would contraindicate it. I told Mum what dose I had accidentally given him and showed her the bottle. I explained that he had had 1mg (dose for a five year old and that he could have had 2mg dose for and eight year old) Senior ENP on duty informed. Notes completed to show that I had given in error. Correct child given dose of Chlorphenamine as per PGD for a rash. I will do a reflection on this incident. Next time I will call the patient back into the unit and check I have the correct patient.	All details of action taken given in action at time of incident box below.	Reflection completed by clinician.	Closed
GHC71995	27/06/2024	23/06/2024	15:00	ICT	ICT Chelt Town Centre DN	Care UK	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug has expired	Administration	Glycopyrronium bromide	Yes	200mcg		Subcutaneous		OOH GP visited patient and administered a stat dose of glycopyrronium bromide at 05:30am. Patient experiencing audible secretions +++ when i visited at 15:00pm, unable to give glycopyrronium as medication expired on 04/2024	Apologised to patients family for delay in treatment and also for out of date medication being administered to patient by OOH GP Contacted OOH GP who did an urgent prescription for glycopyrronium for family to collect Arranged DN visit once medication available in property	Nurse reported incident to OOHS GP and obtained in-date medication. An apology was given to the patient and family as per duty of candour.	Learning for the OOHS GP to check the dates on the ampoules prior to administering medication.	Closed
GHC72043	28/06/2024	22/06/2024	09:30	ICT	ICT Chelt Town Centre DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Insulin glargine	No					The purpose of the visit was to check blood sugar levels and administer insulin. Blood sugars checked as normal, insulin pen/needle primed with 2 units (insulin came out of needle). Insulin administered as prescribed in left side of patient abdomen. The safety needle clicked when pressed onto skin, which is the indication that the needle has inserted. I administered the insulin and counted to 10 seconds before removing the needle. Upon removal, it appeared the insulin had not been administered and it has collected in the safety needle and dripped off the patients stomach. I explained to the patient I do not think the insulin has been administered. Patient stated they did not feel the needle insert.	I contacted Nurse in charge straight away, I explained I had given the insulin and the needle made the click sound which indicated the needle had gone in but after 10 seconds and on removal, it appeared the insulin had not gone in and it had collected in the safety section of the safety needle. Nurse in charge, advised she would send a nurse to see the patient within 1-2 hours to recheck blood sugars and assess the patient.	Reported batch number to the pharmacy for investigation of needle issue. No harm to patient on this occasion however impact on service delivery due to extra clinical intervention required later that day.	impact on service demand and patient care when equipment malfunction occurs.	Closed
GHC72059	28/06/2024	23/06/2024	17:30	Rapid Response & EONS	Rapid Response	Other organisation (please specify)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug prescribed with known allergy	Prescribing	Co-amoxiclav	No					Patient prescribed Co-Amoxiclav by out of hours GP for infection of unknow source. Patient has documented allergy to Penicillin on SystmOne and JUYI. Confirmed with patient, she is well aware of her allergy but did not know Co Amoxiclav contained Penicillin. Her mother and brother are also allergic and her brother suffered an anaphylactic reaction to it. Patient's family had tried to obtain the medication but the prescription was not completed correctly so the pharmacist wouldn't issue the Co-Amoxiclav.	Nil action required because family hadn't obtained the medication and were waiting for Rapid Response to review patient and take bloods. Made family aware of the penicillin content of the medication and that if antibiotics were required, RR would switch to an alternative.	All appropriate actions taken at time of incident. Prescribing clinician spoken to by practice plus.	none	Closed
										Wrong quantity	Administration	Clozapine	Yes	200	100	Oral	Oral					

GHC72060	28/06/2024	28/06/2024	09:30	PICU	Wotton Lawn-Greyfriars PICU	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Bisoprolol	Yes	5	2.5	Oral		Patient A was given his morning dose of medication twice.	Consultant was informed. Advised to check NEWS every 30 minuets for the next 6 hours then drop it to every 2 hours as long as patient is awake to check for bradycardia or hypotension after doubling the dose of Bisoprolol and to inform Duty doctor if there is any concerns.	Duty doctor made aware and patient was monitored over a period of 6 hours, post administration.	Education to nursing staff around ensuring patients medication is signed on the chart to avoid patients receiving their medication twice. However, it is acknowledged that sometimes mistakes are made. The nurse who administered the medication was advised to provide a reflect piece.	Closed
										Wrong quantity	Administration	Folic acid	Yes	10		Oral						
GHC72076	28/06/2024	28/06/2024	11:52	CYPS/PH Public Health Nursing	CYPS/PH-Immunisation Team	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Adverse / allergic drug reaction (when used as intended)	Administration	Diphtheria + Tetanus + Poliomyelitis vaccine	Yes	0.5mls		Intramuscular	Intramuscular	Pupil vaccinated with Diptheria, Tetanus and Polio vaccine at Crypt school, closed his eyes and seemed quieter. I asked if he felt ok, as he seemed 'odd' he stated felt ok and 'just do the other vaccination'. He did not want to lie down and did not look pale. Second vaccine Men ACWY given and he slumped slightly and dropped his head.	2 Colleagues & I assisted him to the ground and elevated his legs. He still did not look pale, and answered my questions. When he was still not feeling well and not wanting to interact I called mum to see if someone could collect him and whether she might have some idea why he might be reacting like this. She suggested getting his older brother, and at this point the pupil stopped answering questions and following instructions. No signs of anaphylaxis, no respiratory or circulatory issues, but I felt concerned and notified mum that I felt the need to call an ambulance to review her son. Ambulance crew assessed and took pupil to ambulance to assess as he complained of chest pains, and he was able to walk himself there.	Team appropriately assessed the young person reactions following vaccination and sought further support from ambulance crew in view that young person was expressing that they had chest pain Mum contacted and made aware of the situation. Vaccination session stopped to enable the team to work together to ensure young persons safety. Once young person assessed and left school under the care of ambulance crew the session was safely completed	Team worked well in recognising potential anaphylaxis and treated the young person based on what they could see seeking the appropriate support from ambulance crew who took young person to hospital for check up.	Closed
GHC72101	29/06/2024	29/06/2024	08:35	North Cotswolds Hospital & GMC	NC Hosp-Cotswold View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Tramadol	Yes	100mg		Oral		Prescription stated Tramadol 50mg capsules 1-2 capsules No more than 4 in 24 hours I administered 2 capsules at 08:30 on signing the prescription chart it flagged up it was too early to administer had another hour & 39 minutes before to could be administered & she had her four tablets in 24 hours.	Ward sister informed & Dr was present on ward. Looking back over her prescription this error had occurred previously. Dr has changed her prescription to Tramadol 50mg 1-2 capsules No more than 6 capsules in 24 hours Apologises given to patient, who informed me that when she's at home she takes 1-2 capsules every 4 hours .	On review of this incident it highlighted that an error was made with the timing of medication administration. Medication was given too early. Correct escalation at the time of the incident. The patient was informed and escalated to ward Doctors. As a result the Medical Team reviewed that the frequency in which this medication can be administered could be increased to every 8 hours instead of every 12.	On review of this incident it recognised an administration error and as a result the medical team have reviewed that the frequency of administration could be increased appropriately to prevent reoccurrence. No harm caused to patient.	Closed
GHC72123	29/06/2024	29/06/2024	17:30	ICT	ICT Glos North South DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Furosemide	No					On arrival patient reports being well. Patient has dosette boxes for medication. Community nurses and carers are to prompt patient for medication. On this evening medication i have noticed the dosette box that is in use is from week commencing May 24 and we are now June. On looking at the new medication dosette boxes there has been a change in medication.	I have gone through the dosette boxes and there are 2 that should not be in use these are now in the top of the kitchen cupboard. Have started new dosette box and put 3 in the medication safe in the kitchen cupboard as there is a change in medication, looking at the new tablets	Thank you for submitting this datix. Identified that not the most up to date dossett box's were being prompting. Safety netted by removing from lock box and ensuring up to date dossett in use. Further safety netted by informing the son of this so that old box's could be removed from property.	Learning points: - Cannot see documentation that this was flagged with care agency, would have been beneficial to carers are checking dates on dossett box's - DNs weren't to be prompting medications, carers are managing this aspect of the patients care. Ensured clear on reminders to avoid confusion.	Closed
GHC72151	30/06/2024	30/06/2024	11:30	ICT	ICT Chelt Town Centre DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Drug administration omitted / delayed	Administration	Parecoxib	No					Visit for syringe pump replenishment. Drug chart has parecoxib 20mg SC BD prescribed, start date 18/6/24 that has not been given.	Confirmed plan to give on discharge letter. Searched S1 notes and no record of decision made to stop or not give. No sodium chloride available to reconstitute dose during visit. Datix completed. Inform late lead and book pm visit	omission of medication evident on investigation. not DOC pathway appropriate as not harm to patient in this instance. Learning discussion had with initial visiting clinician and holistic initial assessment requirements.	Impact of sustained clinician pressure from high service demand and low capacity levels due to vacancy rates, LTS and competency effects on skill mix.	Closed
GHC72158	30/06/2024	30/06/2024	14:06	ICT	ICT Glos North South DN	Self-care	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Monitoring / follow-up of medicine use	Morphine	Yes	Only 4 hours of continuous pump in over 12 hours		Subcutaneous	Subcutaneous	Patient on a syringe driver for EOL symptom control. Had been alarming overnight, unsure cause. Only called into DNs approx 06:00. DN visit allocated to assess and swab syringe driver. Reported by H@H that multiple batteries found beside bed - ? patient had tampered. Only 4 hours of medication had gone through.	DNs visited to replenish syringe driver. Adviced to contact DNs if syringe driver alarms.	- S1 records reviewed. - No harm caused by incident. - Advice given at the time and no further incidents reported. - No further action. - Patient admitted to Sue Ryder on 1/7/24.	- Ensure patients and family are fully informed and aware what to do in the event that a syringe driver is not working or has an issues. - Bearing in mind due to the nature of a persons needs and condition they may forget or become confused and still try to resolve an issue or tamper with Syringe driver. - Ensure always locked and secured in case. This is common practise and part of current training and competency.	Closed
GHC72160	30/06/2024	29/06/2024	12:20	ICT	ICT Stroud SevernHealth DN	Pharmacy-community	Medication incidents	Medication incident involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Missing medication	Pharmacy	Midazolam	Yes	5mgs over 24 hours via syringe driver	5mgs over 24 hours via syringe driver	Subcutaneous	Subcutaneous	on arrival at patient's home needed to clerk in a new bag of medication. During this process found 5 ampoules of Midazolam 10mgs/2mls missing the box from pharmacy stated 10 amps in box but only 5 through check of driver box and surrounding area where medication preparation is completed unable to find missing medication discussed with patient who stated their daughter collected the sealed bag and brought it straight to home address. The bag was sealed when I arrived	all checks made to locate missing ampoules checked and rechecked stock sheets checked with patient and husband who confirmed no other medication stored else where unable to get through to chemist so visited and spoke to Locum pharmacist who agreed it was a mistake and will provide a further 5 amps for family to collect Monday	Nurse took action to check with pharmacy and documented on datix that error made from pharmacy. More ampoules prescribed. No other action required. No errors accord during DN care	Ensure that labels are correct on checking JIC medication in, That this is correct with medication issued	Closed
GHC72184	01/07/2024	01/07/2024	10:45	ICT	ICT Chelt Peripheral DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Preparation by administering clinician(s)	Midazolam	No					Controlled drugs at a patient's property. Counted 33 Midazolam, checked with family that there weren't anymore medications anywhere else in the property. Visiting professional before myself (Hospice nurse) had written 38 as their count, but I could only count 33 in total. Now 32 after using one ampoule for stat dose.	Spoke with triage nurse who advised to datix if medication count did not add up. Will get visiting nurse for syringe driver replenishment to double check when she visits also.	Situation to be monitored via daily clinician visits incident escalated to end of life lead as part of ongoing concerns surrounding commissioned care for hospice nurses.	impact of not clear boundaries for responsibility in patient treatment often effects continuity.	Closed
GHC72193	01/07/2024	18/06/2024	10:00	Assertive Outreach	AOT SC West	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug has expired	Ordering, collection or delivery	Lurasidone	Yes	111mg		Oral		Patient's family had called to say that the [patient] had been left with and provided with out of date medication.	New Chemypacks re-ordered and delivery arranged.	medication audits completed - out of date medication destroyed as per policy	Staff reminded to check dates before giving medication out	Closed
										Drug has expired	Ordering, collection or delivery	Metformin	Yes	1000mg		Oral						
GHC72212	01/07/2024	28/06/2024	17:28	Stroud Hospital	Stroud Hosp-Cashes Green Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Tramadol	Yes	200mg		Oral		Patient has been given Tramadol immediate release 50mg 4tablets instead of Tramadol prolonged release 50mg 4 tablets by my colleague JW on 28/06/24 at 17:28, KW on 29/06/24 at 08:55, BDCM on 29/06/24 at 18:10 and I have counter signed all three times. Only realised my mistake on 30/06/24 at 08:40 during the drug round.	Patient has been informed. Requested Prolonged release capsules from pharmacy. Explained patient that Oramorph is prescribed as required and he could have up to 20mg in 24 hours.	Staff members involved have been spoken to and realise their mistake. They have reflected upon this. The importance of and differences of immediate release vs modified release was discussed in the next ward meeting. No concerns re. bad practice, or process not being followed, this appears to have been human error, and was picked up by a staff member who was present in all 3 administrations. No harm came to patient and appropriate actions taken by nursing staff on identification of error.	Staff members involved have been spoken to and realise their mistake. They have reflected upon this. The importance of and differences of immediate release vs modified release was discussed in the next ward meeting. No concerns re. bad practice, or process not being followed, this appears to have been human error, and was picked up by a staff member who was present in all 3 administrations. No harm came to patient and appropriate actions taken by nursing staff on identification of error.	Closed
GHC72242	02/07/2024	01/07/2024	09:30	Charlton Lane Hospital	Charlton Lane-Chestnut Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Prescribing	Methotrexate	No					Both Metoject and Zlatal injection pens were prescribed inpatient on admission but patient should not be on both. Patient was on Metoject 17.5mg SC every Wednesday as per GRH discharge summary dated 24/6/24 and Zlatal was discontinued.	Spoke to consultant during MDT meeting about concerns of having both of these prescriptions as there might be risk of duplicate doses of methotrexate. Advised consultant to stop Zlatal and let patient continue on Metoject only. Zlatal was discontinued as per pharmacist intervention . This near-miss incident was discussed with both medics and supervising pharmacists.	Correct actions taken and consultant corrected prescription sheet.	Good observation by trained nurse and action taken immedicably.	Closed
GHC72245	02/07/2024	01/07/2024	10:00	ICT	ICT Chelt Town Centre DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug has expired	Administration	Other (unlisted)	Yes	8 units	yes	Subcutaneous	Subcutaneous	I visited patient on the 2/7/24 for BGL and Insulin administration and noted that drug chart and notes on system one indicate insulin administered in the 1/7/24 ran out on the 30/6/24.	New insulin pen used today , checked stock to ensure that no more out of date stock in property, spoke with Lead who advised to datix incident.	Discussion with clinician involved. requested review of 6rs of medication administration. refer lection requested.	n/a	Closed
GHC72250	02/07/2024	26/06/2024	12:30	Recovery	Recovery Gloucester	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Zopiclone	No					Seven tablets of Zopiclone was in the pharmacy store in the 9th Jan 2024. When checked in June 2024 this was no longer in the store and the medication had not been signed out. Care Co-ordinator had not given the medication to patient and had not destroyed either. No response from team members if someone else had destroyed in my absence.	Discussed with care co-ordinator of patient Discussed with line manager Email sent to team Line manager escalated to Clinical Lead and Lead Nurse Practitioner	Issue noted on a routine regular medication audit by pharmacy room lead. Reminder of importance of disposing of medications and recording this when no longer required (and promptly) both in clinical notes and on signing in/out records.	Recent updated SOP and upcoming change to medication signing in/out form already in process to ensure easier tracking and recording of medications being delivered, dispensed or destroyed. No evidence or clarity regarding where medication went, likely to have been destroyed or given but not recorded. Reminder and support to staff involved in medication management procedures of new processes and importance of accurate and timely recording both in pharmacy room and on patient records.	Closed
GHC72252	02/07/2024	02/05/2024	09:00	ICT	ICT Chelt Peripheral DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong time / frequency	Administration	Insulin glargine	No					I visited patient on Monday 1st July to administer insulin, drug chart stated last dose was given Friday 28th June, asked patient if she had a visit over the weekend for insulin administration, patient confirmed no one arrived Sunday but couldn't remember if anyone visited Saturday. Systmone states last visit was 28/06/24. Patient missed 2 days of insulin and didn't have visits booked for the weekend. BGL out of range as a result.	Informed network lead, informed Band 7.	on investigation omission of visits booked appears to be as a result of introduction of new insulin ledgers for the locality. feedback to the lead of this project for awareness and process change for safety netting. patient BGM levels raised however no systematic event due to isolated raise similar to increased diet intake of glucose.	new process reviews prior to implementation	Closed
GHC72286	03/07/2024	03/07/2024	10:00	ICT	ICT Forest South DN	Other organisation (please specify)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong quantity	Administration	Memantine	Yes	20mg	10mg	Oral	Oral	Colleague attended patient for routine support with BGM and insulin administration. On arrival, patient had already left the house. Colleague contacted patient's daughter to locate her, daughter reported that patient had seemed more drowsy over the last few days, colleague checked medications and noted that memantine 10mg had been administered via the dosette box and via the medication box, doubling dose from 10mg (as prescribed) to 20mg. This has been the case since 27/6/24	Note prescription attached advises that memantine was in the dosette box and to not administer from box as well Spoke to GP who advised that this increased dose was still within normal dosing ranges, and did not request bloods at this time, but to advise the patient to continue taking the normal dose from tomorrow Colleague advised family to continue normal dosing and to not administer from box as well Advised colleague to take observations at this time, and gave GP advice as above Obs checked	Full set of observations taken and spoke to GP for advice. Bloods taken. Nil evidence of side effects. Daughter now unsure of whether double dose given as medications were taken from old medidose tray. Advice given regarding removing old medidose trays from the house to prevent further error.	Thank you for your report. All appropriate preventative actions have been taken. No learning identified	Closed
GHC72293	03/07/2024	28/03/2024	16:30	ICT	ICT Cotswold North DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Insulin glargine	Yes	12units	10units	Subcutaneous	Subcutaneous	having issues with medications, as doses and medications changed, no discharge summary in property, new medications haven't been order. contacted Son who sourced an old pill box but some of the doses was different. email sent to surgery to confirm what medications patient should be taking and what doses. email recieved confirming medications and also stated that patient should be on semglee 10units and humulin I 4units. DN visiting since discharge have been administering old dose prior to admission (lantus 12units and humulin i 6units	made contact with Nursing lead for advice. BGL are stable and with target range so advised RN visit in the morning and assess contact GP to make them aware. get new prescription charts written duty of candour to patient. GP Review BGL and dose and is happy that BGL are stable and want to keep patient on 12units of lantus and 6units of humulin i	Patient admitted to hospital on the 2nd June due to confusion and reduced mobility Patient discharged from hospital on the 23rd June. Referral made into community nursing team to recommence insulin on the 24th June. Advised changes to insulin dose to Humulin I 4 iu and Lantus 10iu and new drug chart would be with the patient. Patient well known to the community nursing team. Patient triaged by referral centre and appointment booked for 24th July. Appointed booked and added to appointment for following day to advice of change to insulin doses. Patient has a history of memory loss As patient had been in hospital a new comprehensive patient assessment was completed on the 24th July however no documentation of changes to insulin. Noted by HCA who went to give insulin on the 2nd July of a discrepancy with patient insulin. Liaised with NOK and GP. Apologise given to patient and son.	To ensure discharge summary is with person transporting patient home as patient has memory issues and lost the discharge summary. No new drug chart sent home with patient New patient assessment to check if any changes to medication if recently been in hospital Ensure community nurse checks appointment on ledger check if any added detail placed on the appointment Community nursing lead discussed at Team Time with whole team and minute to share with additional staff who were not present at Team Time to ensure they obtain a discharge summary if patient is discharged home - especially those patients with memory issues who may not be able to retain new information	Closed
GHC72329	04/07/2024	01/07/2024	09:50	CYPS/PH Public Health Nursing	CYPS/PH-Immunisation Team	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Human papillomavirus vaccine	Yes	0.5ml		Intramuscular		Young person attended a catch-up vaccination session at School on 1/7/24 for a HPV vaccine. Previously Absent from the main session on 19/1/24. Consent gained from parent on 10/6/24 as documented on consent form to have the vaccine at the catch up session at school. Young person signed the consent form on the day to consent to having the vaccine. Vaccine was given by nurse. Telephone call to the office on 2/7/24 from parent. Admin team took the call. Parent stated that son should not have had vaccine on 1/7/24,Following absence from main school session, Mum contacted GP and had HPV on 2/5/24 out of county. Mum shared that when she spoke to someone in our office on 10/6/24 she staff member said that the vaccine was not showing up on our system and that he hasn't had it yet. No record on CarePlus. Mum stated that she was told that we would be in contact nearer the time of school revisit to check to see if young person had it. Conversation not documented anywhere.	Senior Immunisation nurse called parent at 13:30 to discuss incident. Mum unhappy that child had vaccine. Reassurance given and discussed side effects and minimal risk to young person having had another dose of the HPV vaccine. Informed what i can see documented on consent form, consent had been gained. Mum said that did not happen. Apologies given and offered patient experience details as mum would like this escalated. Mum declined to take details due to personal disability circumstances but gave me permission to give her contact details to the experience team. Contacted team and they will contact parent.	On reviewing incident, it was highlighted that length of time elapsed between team calling mum to confirm consent was still in place and that the young person had not been elsewhere for vaccination and the school session was to great. Whilst the team would have checked CHIS to see if the young person had received the vaccine prior to the catch up clinic, owing to the young person being with a GP out of area the information is not shared with CHIS south west. Additionally mum reports that she had informed the team that he had received the vaccine however this was not documented.	The need for accurate documentation when speaking to the young person or parent. The need for the team to ensure that calls to parents to confirm consent are not made any sooner than 1 working week to the parents to reduce the risk of double vaccination. Discussed at monthly meeting with commissioners and to review whether team would be able to see out of area HPV records via NIVS	Closed
GHC72350	04/07/2024	09/05/2024	11:30	Long Term Conditions	Heart Failure	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Sacubitril + Valsartan	No					Helpline call from discharged patient. Has not been taking Entresto medication for 2 weeks due to the pharmacy telling her there is a supply issue and they are unable to get hold of the tablets.	I have asked the patient to ring the GP surgery, ask for a paper copy prescription for the Entresto and source else where	Pharmaceutical company state there is no shortage of Entresto. Chemists to do not stock enough and need to ring the AHA helpline to up their quota but that are not doing this. Plan in place to let pharmaceutical company know if ongoing issues so they can address them with chemists.	NA	Closed
GHC72386	05/07/2024	04/07/2024	14:30	ICT	ICT Cotswold South 2 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Morphine	No					Patient admitted to Cirencester hospital on 03/07/24, self discharged on 04/07/24. Patients stock of controlled drugs was taken to the hospital and returned home with patient. On the 02/07 the number of Morphine Sulphate 10mg/ml ampoules remaining was 12. I counted 10 ampoules on 04/07.	Morphine sulphate counted and recorded on stock sheet. Photograph taken. Nursing lead informed.	DN reviewed patient and after discussion with family it was agreed that patient had likely not returned from hospital with correct medication. Patient had enough medication at home and this didn't cause delays in care or treatment. Datix'd and escalated appropriately.	Community hospitals should make sure controlled drugs are counted in and out on admission and discharge. Conversation was had with ward at time of incident.	Closed
GHC72457	06/07/2024	05/07/2024	20:30	Cirencester & Fairfrd Hospital	Ciren Hosp-Windrush Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Drug administration omitted / delayed	Administration	Other (unlisted)	No					The patient in 5c is prescribed with IV antibiotics Clyndamycin 1200 mg as IV . This patient belongs to blue team and I was on red team .His medications is actually due at 18:00 but his nurse planned to administer this IV drug after the drug rounds with other patients .As the shift was too busy ,couldn't manage to administer until 20 :00 .After administering controlled drugs we nurses together checked due antibiotic and signed on administration record .She agreed me that she is going to administer it even after handover . After handing over TO THE NIGHT STAFF I left the ward .At ROUND 21:30 I recieved call from night staff of blue side and asked about the confirmation regarding antibiotic administration as it was signed and she got handover that its not administered .I explained what happened .She confirmed with the other nurse that it is not administered .	Night staff changed the records in system one by marking error. she administered the dose which was due at 22:00 and patient missed 18:00 . said sorry to the patient informed doctor regarding the incident .	This medication was administered once the omission was noted, and all correct actions taken to ensure that documentation was correct. The Doctor has been informed, and an apology made to the patient concerned.	The RNs involved correctly checked that the drug had been administered, and corrected this when the ommission was noted.	Closed
GHC72459	06/07/2024	04/07/2024	13:35	Wotton Lawn Hospital	Wotton Lawn-Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Use / possession of over-the-counter (OTC) medicine	Paracetamol	No					-Patient went AWOL upon return. -Staff requested the patient to empty his pocket. -Staff found 16 tablets of paracetamol box from his jacket pocket in that 08 tablets left.He reported that he did not buy the tablets, he picked the packet from the floor and denied consumption of medication. -DMO came and reviewed. -He refused physical observations.		risk ax updated reviewed by medics	N/A	Closed
GHC72507	08/07/2024	28/06/2024	15:00	ADHD & ASC Countywide	ADHD Adults Team	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Prescribing	Lisdexamfetamine	No					Incorrectly written prescription of 70mg Lisdexamfetamine, did not include when to take the medication on prescription and therefore declined by pharmacy	Patient contacted the service to advise us of this, new prescription issued when I returned from leave.	Discussed with the prescribing Nurse, A part of the CD prescription was not completed currently. Reviewed prescription writing and correct processes needed for CD prescriptions	All prescribers in the team reminded of CD writing process	Closed
GHC72526	08/07/2024	28/06/2024	10:00	ADHD & ASC Countywide	ADHD Adults Team	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Prescribing	Lisdexamfetamine	No					Prescription of Lisdexamfetamine written incorrectly, did not include when to taken the medication. Prescription was sent 1st class, signed for delivery and when the patient contacted the pharmacy, appeared to have been lost. However, when found, it became apparent the prescription was not completed correctly and therefore medication not supplied.	Prescription written again and patient contacted to apologise and advised they collect from the office.	Discussed with the prescribing Nurse, A part of the CD prescription was not completed currently. Reviewed prescription writing and correct processes needed for CD prescriptions	All prescribers in the serivce reminded of CD writing needs	Closed
GHC72553	08/07/2024	08/07/2024	18:30	North Cotswolds Hospital & GMC	NC Hosp-Cotswold View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Dalteparin	Yes	18000	5000	Subcutaneous		18,000 units fragmin administered to patient instead of 5,000 units. Fragmin found in trolley where 5,000 usually is and picked up in error.	Dr informed who has checked patients weight and kidney function and has states patient will be okay and dose will wear off in 24 hours. She states there is probably no clinical need to hold aspirin and clopidogrel but has held in morning as a precaution. Patient and her daughter informed of error and apologies given. I have explained the risks to them and also explained that the doctor has reviewed patient's record and dose given. I have asked patient to call always if she needs the tiolet in the night. and I will ask the 1:1 staff on the night shift to monitor patient and listen out for her bed sensor alarm and walk to patient to the tiolet during the night.	Apology given to patient and NOK. DR R/V'd patient at time of incident. Staff reminded to not keep non stock meds in WOW and to remove meds from WOW after drug round as per SOP.	Staff reminded to not keep non stock meds in WOW and to remove meds from WOW after drug round as per SOP.	Closed
GHC72568	09/07/2024	08/05/2024	12:30	CYPS/PH Public Health Nursing	CYPS/PH- School Nursing	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Information / advice to patient not given / wrong	Information / advice to patients	Other (unlisted)	No					According to the notes on System one, parent was advised to give child a specific brand of vitamins to take. The child is allergic to certain ingredients found in the vitamins suggested.	Incident discovered on the 5th July 2024 on review of record notes. Line manager informed and parent contacted to see if advice was taken and to ensure ingredients list are checked before giving to the child. Discussed with member of staff and advised not to give specific brand named products and to let parent know to get more guidance from pharmacists or GP	Discussion had with Team leads from other School Nurse localities to ascertain what is the current practice of all School Community health facilitators.(SCHF'S) Team Leads to advise all SCHF'S not to recommend certain brands of vitamins, the advice needs to remain general. SCHFS to advise parents to seek GP or pharmacist advice Team leader had a reflective discussion with staff member who recommended the specific vitamin. The concerning risks discussed and understood.	Errors were rectified in a timely manner – Parent of young person was contacted Staff member was open and honest and reflected the NHS duty of candour There has been good reflection and discussion individually and within the team All staff to feel confident in recommending a general vitamin, not brand specific and the reasons for this. Staff encouraged to seek support if in doubt. Investigation shared at locality and countywide.	Closed
GHC72598	09/07/2024	09/07/2024	14:15	Crisis Resolution Home Treatmt	CRHT Cots & Vale	Pharmacy-provider	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Pharmacy	Quetiapine	No					incorrect medication doses arrived from pharmacy, noticed when signing in therefore were not given out to patient.	Pharmacy contacted and informed of error, medication returned to pharmacy.	No further action taken. Medication checked as per process and discrepancy noted. Medication returned to pharmacy and correct medication dispensed.	No lessons learnt. Processes followed, discrepancy noted, medication returned to pharmacy and correct medication doses collected	Closed
										Missing medication	Pharmacy	Lorazepam	No									
GHC72615	09/07/2024	09/07/2024	12:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Amoxicillin	Yes	1000mg	1000mg	Oral	Oral	2 doses of prescribed medication were missed.	Duty doctor was informed and timing of following dose was readjust.	On investigation only 1 dose missed. Nurse involved completed reflection demonstrating learning.	No further lessons identified	Closed
GHC72639	10/07/2024	10/07/2024	09:30	Stroud Hospital	Stroud Hosp-Cashes Green Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Medication storage issue	Disposal	Morphine	No					At approx 0930 10/7/24 I went into the treatment room and observed an open vial of Morphine sulphate and an open vial of Midazolam left in a try on the side.	Checked with colleague on duty. This was not in use by them. Together myself and colleague checked CD book and stock count. These vials appear to be patients own stock. 9 remaining Morphine sulphate and Midazolam vials in cupboard. One dose of each given on 8/7/24. Informed ward manager, and Datix completed.	Email sent out to every RGN - there is a joint responsibility to ensure the clinical environment is clean and tidy. RGNs who administered medications have apologised, they had been distracted and did not return to the treatment room following administration, each thinking the other had thrown the vials away. No medication left in vials, however posed a risk of sharps injury due to broken glass.	Email sent out to every RGN - there is a joint responsibility to ensure the clinical environment is clean and tidy. RGNs who administered medications have apologised, they had been distracted and did not return to the treatment room following administration, each thinking the other had thrown the vials away. No medication left in vials, however posed a risk of sharps injury due to broken glass.	Closed
										Medication storage issue	Disposal	Midazolam	No									
GHC72669	11/07/2024	09/07/2024	22:00	Cirencester & Fairfrd Hospital	Ciren Hosp-Windrush Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Controlled stationary (medication related)	None (no harm caused by the incident)	Missing medication	Ordering, collection or delivery	Insulin isophane biphasic human	No					Insulin for the patient was not ordered so the patient was not able to take the medication on his prescribed time.	Apologised to the patient for the inconvenience caused and he accepted it and ordered the medication ASAP.	This will be discussed at Team Updates, and will be regularly revisited to ensure that registered nurses need to explore if medication is available elsewhere - including on the other inpatient ward. Nurses will be reminded to double check medication supplies during medication rounds, to ensure new stock is ordered in a timely fashion. This particular incident was caused by human error, and the nurse concerned has been asked to reflect on the incident.	Check if medication available elsewhere in the short term. Ensure medications are ordered in a timely manner. Seek medical advice if appropriate.	Closed
GHC72705	11/07/2024	11/07/2024	01:00	Charlton Lane Hospital	Charlton Lane-Chestnut Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Clozapine	No					Cup found in communal areas with a tablet in (appears to have been a ensure drink) Left on a table in the dinning area	Removed and disposed of	The actions taken at the time of incident were followed correctly.	All staff emailed to ensure when giving the patient medication that they remain with her until the medication has been taken.	Closed
GHC72716	11/07/2024	10/07/2024	13:00	ICT	ICT TWNS OT	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Omeprazole	Yes	20mg	40	Oral		I visited patient yesterday afternoon to check any discrepencies regarding medication as another member of staff had noticed some medication had not been signed for, After initial count of all medication i discovered 3 errors of missed dose medication.Over a two week period 26/06 - 10/07 three 20 mg lansporazole had not been given, patient is prescribed two 20mg capsules a day, three 25mcg stexerol D3 tablets had not been given, patient is prescribed two 25mcg tablets a day ,and one 400mcg tamsulosin was not given, he is prescribed one a day.	Reported to reablement lead manager.	Discussion with SRA, it would appear that a reduced dose of the medications highlighted may have been administered over a two week period. This was evident as the SRA started brand new boxes containing the exact amount for 2 weeks when initially completed the MAR. When she re-visited to update and complete new MARS the tablets should have all been gone but three remained in each of the boxes highlighted. It is assumed that on three occasions only one of each of the tablets were administered by the RA's visiting however it is impossible to confirm as the new MAR paperwork does not include a medication daily count. Email sent to Homefirst and Reablement Service Lead and Homefirst and reablement Professional and Development Lead explaining the situation and raising concerns that we can no longer count meds, without this it is very difficult to investigate the error accurately. Both state in email replies that there is no plan for MAR to include a count and will not be introducing this despite concerns raised. Team aware of error and reminded to be vigilant at all times when supporting with administration of medication. No adverse side effects for the patient as a result. SCNA involved and dossette box now in place to prevent future errors where possible.	Reablement lead to monitor the impact of having no medication count on the new MARs charts. Reablement staff reminded to be vigilant when supporting with medication administration and to highlight and escalate any errors (where possible).	Closed
										Drug administration omitted / delayed	Administration	Colecalciferol	Yes	25mcg	50mcg	Oral						
										Drug administration omitted / delayed	Administration	Tamsulosin	No									

GHC72726	11/07/2024	11/07/2024	12:00	ICT	ICT Stroud Cotswolds DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Oxycodone	No					Daughter rang in, told me that sd had been replenished at 12, but that the infusion hadn't been started and that it was paused, she noticed this at 3pm when she heard the bleeping noise. There was a chc nurse? in the property at the time, so pressed start on the sd. Daughter wishes for nurse visiting at noon not to return again, daughter was quite rude on the phone.	I asked how her mother was at present and if it had an impact on symptoms, she said that it didn't have an impact and that she was currently asleep. I apologised to her for the situation and gave reassurance on the phone.	12/7/24- incident discussed with nurse who was distressed that she may not have started the syringe driver.Nurse has apologised and I have advised I will contact the daughter to convey such. Contacted daughter who accepted apology and will also convey apology to her mother.	Learning for the nurse identified and discussed.	Closed
GHC72751	12/07/2024	16/04/2024	12:30	Sexual Health Service	Sexual Health Preg Adv PAS	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Mifepristone	Yes	200 mg		Oral	Oral	Seeing a 14yr old patient in clinic with her mother in consultation, gave the patient her mifepristone tablet which is part one of abortion EMA regime prior to Doctor in clinic prescribing. I thought I had asked for all prescribing to be done when I took patient to my room after the doctor had performed the US scan.	After the patient had left the clinic I asked the doctor to prescribe the medication that I had given.	Discussed with clinician who had administered mifepristone and DR who they had liaised with. Case based discussion had occurred with Dr, but appears to be a communication failure in securing the prescription.	Raised awareness among the team to ensure clear instructions / requests are made.	Closed
										Drug chart errors - not signed, recording, other	Administration	Atorvastatin	No									
										Drug chart errors - not signed, recording, other	Administration	Cyproterone	No									
										Drug chart errors - not signed, recording, other	Administration	Haloperidol	No									
										Drug chart errors - not signed, recording, other	Administration	Melatonin	No									

🟩	Drug chart errors - not signed, recording, other	Administration	Paracetamol	No									🟩
🟩	Drug chart errors - not signed, recording, other	Administration	Other (unlisted)	No									🟩
🟩	Drug chart errors - not signed, recording, other	Administration	Olanzapine	No									🟩
🟩	Drug chart errors - not signed, recording, other	Administration	Other (unlisted)	No									🟩
🟩	Drug chart errors - not signed, recording, other	Administration	Ibuprofen	No									🟩

GHC72778	12/07/2024	08/06/2024	18:00	Charlton Lane Hospital	Charlton Lane-Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Lamotrigine	No					Following a medication administration audit it was found that eight patients RIO evening medication did not have an action attributed to it. This occurred for one patient during the 18:00 to 20:00 round and eight during the 20:00-23:59 round.	The Nurse concerned will be contacted via the Clinical Support Manager - Temporary Staffing and asked for a report and/or reflection as per trust policy. Modern Matron And Ward Manager were informed.	No harm caused to patient Nurse made aware - reflection required	NA	Closed
										Drug chart errors - not signed, recording, other	Administration	Rivastigmine	No									
										Drug chart errors - not signed, recording, other	Administration	Amoxicillin	No									
										Drug chart errors - not signed, recording, other	Administration	Chlorhexidine	No									
										Drug chart errors - not signed, recording, other	Administration	Docusate sodium + Glycerol	No									

🟩	Drug chart errors - not signed, recording, other	Administration	Lorazepam	No				
🟩	Drug chart errors - not signed, recording, other	Administration	Other (unlisted)	No				
🟩	Drug chart errors - not signed, recording, other	Administration	Sodium valproate	No				
🟩	Drug chart errors - not signed, recording, other	Administration	Chlorpromazine	No				

🟩	Drug chart errors - not signed, recording, other	Administration	Other (unlisted)	No				
🟩	Drug chart errors - not signed, recording, other	Administration	Other (unlisted)	No				
🟩	Drug chart errors - not signed, recording, other	Administration	Diazepam	No				
🟩	Drug chart errors - not signed, recording, other	Administration	Senna	No				
🟩	Drug chart errors - not signed, recording, other	Administration	Betahistine	No				

GHC72786	12/07/2024	11/07/2024	18:00	ICT	ICT Chelt St Paul's DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Insulin human	No					Visited on evening of 12 July to administer evening insulin, Whilst i was checking the evening drugs chart i noticed a day was missing, I checked through the electronic record and could not see an entry for the 11th July evening, Asked the patient and she said she didnt think that she had been given her insulin the night before, I checked her appointments and there was only one appointment made for the 11th July.	Apologised to patient, informed late lead and completed Datix	15/7/24 All appropriate actions completed by clinician. All other onward visits were booked apart from isolated one missed. Clinician visiting 11/7/24 am to complete a reflection and discussed in team time the importance of booking onward appointments. No harm to patient & BGL 12/7/24 within their therapeutic range	15/7/24 Staff to ensure onward visits booked	Closed
GHC72791	13/07/2024	07/05/2024	12:00	Charlton Lane Hospital	Charlton Lane- Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Paracetamol	No					During the May missed dose audit, a missed dose was identified during the lunchtime round on 7th May.	Staff bank have been contacted to request a reflection from the nurse completing the medication round.	Reflection received from nurse, demonstrates learning.	No further lessons identified	Closed
GHC72792	13/07/2024	29/06/2024	14:00	Charlton Lane Hospital	Charlton Lane- Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Other (unlisted)	No					During the June missed dose audit, a missed dose was observed during 14:00 medication round.	Staff bank have been contacted to request a reflection from the nurse completing the medication round.	Reflection completed by nurse	No further lessons identified	Closed
GHC72793	13/07/2024	13/07/2024	00:30	District Nursing (ENDS)	ENDNS- Out of Hours DN	GP	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Prescribing	Morphine	No					patient called out for a stat dose for agitation and pain, on arrival to house when checking drug chart to see what we could administer noticed drug chart had no start dates written on.	OOH GP informed , verbal order taken family informed datix completed message handed over for day team to get chart rewritten.	No action required. No drug chart re written. No harm caused to patient	DN staff to check that all drug charts are correctly written before taking to patient property	Closed
GHC72855	14/07/2024	13/07/2024	07:20	Charlton Lane Hospital	Charlton Lane- Willow Ward	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Other (unlisted)	No					Patient at A&E (escorted by HCA) had become confused, anxious and agitated and was not responding to distraction or verbal reassurance. HCA's requests for PRN medication were denied by A&E staff. The Willow Ward night nurse spoke to a an A&E staff member over the phone and was told to come to A&E and give the patient the PRN medication themselves. Duty Dr was consulted but felt unable to interject in events on A&E.	Charlton Lane Modern Matron, Manager and Consultant Psychiatrists will be informed about these events via this DATIX and via a follow up e-mail.	Managed appropriately	NA	Closed
GHC72939	16/07/2024	11/07/2024	14:00	ICT	ICT Glos North South DN	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Ordering, collection or delivery	Cyclizine	Yes	100mg		Subcutaneous	Subcutaneous	Planned visit for syringe driver. Patient discharged from 9B at Gloucester hospital and for us to replenish the syringe driver. The syringe driver contained Cyclizine but the patient had not been sent home with any cyclizine so initially we were unable to replenish the driver.	Contacted GP and requested urgent prescription, photograph sent of label on driver and drug chart and family member went to collect. Apologised to the patient and family for the delay. datix submitted.	Delay in treatment but no lasting harm. Changed to near miss as potential for harm if we were unable to obtain cyclizine in the community or further delays with prescribing/dispensing. Refer back to PST to review with acute trust.	Discharging team/clinician to ensure all medication needed is with patient of discharge to prevent any delay in treatment and potential harm to patients.	Closed
GHC72954	16/07/2024	15/07/2024	11:00	Complex Care at Home	Complex Care at Home Glos	Pharmacy- community	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong drug / medicine / item	Pharmacy	Perindopril erbumine	Yes	4mg	0mg	Oral	Not applicable	Patient had received new dosset box medication which she has been using since 12th July 2024. Dosset box contained Perindopril which should have been omitted and did not include Spironolactone	Rang GP spoke to staff to highlight concern that dosset box was not correct and concern regarding patients kidney function. Staff member was going to arrange for pharmacy to collect and re dispense correct doses. Visited 16th July - dosset boxes not collected. Patient has dementia so is very routine with her medication. Rang GP to discuss he agreed to contact pharmacy to resolve. Bloods taken to assess renal function. Tried to call pharmacy to discuss - closed so unable to action.	Review of patient records and incidence. Reported monitored patient and followed up incidence. Medication removed from dosette by pharmacy by reporters visit dated 26/7/24. Clinical observations taken and monitored. All actions timely and appropriate.	All actions appropriate	Closed
										Wrong drug / medicine / item	Pharmacy	Spironolactone	Yes	12.5mg	25mg	Oral	Oral					
GHC72963	17/07/2024	16/07/2024	20:00	District Nursing (ENDS)	ENDNS- Out of Hours DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Stock balance recording errors / discrepancies	Morphine	No					Visited patient to perform Role. When checking the stock record for morphine sulphate 10mg / 1ml injections, 10 ampules was documented being in home but only 5 ampules found.	Checked all medication - no further morphine sulphate injections found. Checked pharmacy label on morphine box, it appeared only 5 ampules were dispensed from pharmacy not 10 ampules as documented. Discussed with daughter and she verified the above.	Reviewed notes from staff member visiting 5 ampules were only given by pharmacy. 5 ampules listed on box. Daughter confirmed only 5 ampules collected from pharmacy.	Spoke to band 7 for advice regarding stock checks, monitor for localities increase in discrepancy. No lessons learnt	Closed
GHC72986	17/07/2024	17/07/2024	13:30	ICT	ICT Stroud BerkeleyVale DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Stock balance recording errors / discrepancies	Midazolam	No					Visited patient for verification of death. On stock check of medication, 5 vials of midazolam missing ? if intial stock check incorrect as stated 10 vials however box prescribed inline with that date for 5 on prescription label. No error noted on Drug chart and family not aware of any more meds being brought into the property and actual amount in property tallies with GP record of prescribed medication		Discussed with staff involved, Wrong count documented, so no missing drugs just recorded wrongly	Staff advised to be vigilant when documenting controlled drugs and to check all boxes	Closed
GHC73026	18/07/2024	06/07/2024	08:30	ICT	ICT Forest North DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Prescribing	Oxycodone	Yes	20 mg		Subcutaneous		Was contacted by Community Nurse who had visited patient for syringe driver replenishment. She informed me that she had been given a verbal order from a senior community nurse who was not on shift over what to add into the syringe pump. She had contacted this nurse as she had the new drug chart in her home that was for use on the day she visited. This was a visit on a Saturday morning. Advised nurse to complete a datix but have been unaware up until this point that this had not happened. Patient did not come to any harm. S1 notes from date of incident state the drug chart for use on that day was in a nurse base office. the visiting nurse had looked for this drug chart in the office but could not find it and as such contacted the senior community nurse who had informed her it was there.	Discussed with nurse who had replenished driver over policy and safe practice. Thanked her for escalating concerns Ensured her well being was managed as she was very distressed Escalated to line manager of both nurses. advised for datix to be completed.	HOP discussion with those involved review & support around INMP policies and procedures indicated.	Communication between nurses and colleagues & easy access to prescription charts supports patient and nurse safety.	Closed
GHC73029	18/07/2024	05/07/2024	12:00	Charlton Lane Hospital	Charlton Lane- Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Prescribing	Dexamethasone	No					Cataract surgery occurred end of may, initially prescribed 4 week course of tobradex. Follow up appointment on 8/7/24 where tobradex (antimicrobial + dexamethasone) had been completed, was issued dexamethasone only eye drops for BD for a week, followed by OD for another week. Patient admitted evening of the 11th, prescribed dexamethasone only eye drop (maxidex) but then told by pharmacy to discontinue on the 12th as last available clinic letter and last hospital prescription was for tobradex. Over the weekend family raised concerns about missing medication, and dexamethasone prescribed but drops also lost. Medication reviewed on 16th and tobradex restarted following family discussion and pharmacy documentation. On the 18th eye clinic contacted, confirmed that dexamethasone only eye drops should be taken and by now should be once daily for 5 more days.	notified consultant, notified family, medication corrected.	Incident appropriately managed when identified Documentation external to trust appears to have been issue	No further lessons identified for trust	Closed
GHC73036	18/07/2024	18/07/2024	10:00	ICT	ICT Chelt Peripheral DN	Nursing / residential home	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Ordering, collection or delivery	Other (unlisted)	No					- Bladder washout solution not ordered so unable to administer bladder washout.	- Put urgent order through GP for washout solution. - Checked catheter is still draining. - Made care staff aware.	- discussion to be had with care staff about ordering stock - conversation to be had with staff to remind them to check stock level at each visit	- stock levels to be check at each visit	Closed
GHC73073	19/07/2024	19/07/2024	11:20	ICT	ICT Chelt Town Centre DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Stock balance recording errors / discrepancies	Buprenorphine	Yes	10mcg / hr patch	10mcg / hr patch	Topical	Topical	Routine visit for buprenorphine patch changed. Whilst completing drug chart and stock check, I noticed no stock check was completed at the previous visit when patch was administered.	Photo taken and datix completed.	Reminder sent regarding stock sheet implementation and update responsibility.	Impact of excessive pressure on staff clarity of thought due to increased LTS and vacancies.	Closed
GHC73078	19/07/2024	18/07/2024	14:00	ICT	ICT TWNS OT	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Information / advice to patient not given / wrong	Monitoring / follow-up of medicine use	Metformin	No					During home first therapist assessment it was identified that the patient had not taken any medication since her discharge from hospital. With consent the patient's bags were checked and a discharge summary found which listed medications prescribed whilst in hospital as well as a new diagnosis of type II diabetes. Unopened boxes of medication also found. The patient did not appear to be aware of her diagnosis of diabetes or that she had been given medication to take when she returned home. The patient stated that she does not like taking pills.	Discussion held with patient re. the importance of taking medication. Call made to care agency following the visit to request support with medication at care visits- they advised OT they would complete a MAR chart that evening. GP and social worker informed the following day.	Appropriate datix thank you and appropriate action taken, following the datix reablement services had spoken with GP, Care agency and MAR charts were added, SCNA review bloods were taken and patient was educated around diagnosis and medications. noted patient to be undergoing investigations into a dementia diagnosis patient was discharged with TDS POC inclusive of medication administration	effective care and discharge planning given please share this teaching with students and colleagues	Closed
										Information / advice to patient not given / wrong	Information / advice to patients	Gliclazide	No									
										Information / advice to patient not given / wrong	Information / advice to patients	Folic acid	No									
GHC73188	22/07/2024	21/07/2024	18:00	Cirencester & Fairfrd Hospital	Ciren Hosp- Windrush Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Prescribing	Insulin isophane human	No					Patient admitted to the ward on 20/07/24 during evening with paper medication chart .On 21/07/2024 i administered all his due medications including insulin with the paper chart .Immediately after my drug rounds ,i tasked the duty doctor to do the medication clerking to system one .After some time , when i checked on the system one i realised clerking has been done .I followed system one for rest of my medication rounds . When i went for my 18:00 medication administration ,i noticed that his insulin prescription is not on the system one as i already noted in the morning from paper chart that he is getting insulin injection twice daily (08:00 and 18:00) .I thought its been reviewed and cancelled by the doctor due to some reasons .His BM was 8.3 in the evening and he had 1 G of metformin as a regular dose at 18:00 .So i was not concerned about his blood sugar .During handover to night staff i realised that i should have ring the out of hours to confirm the prescription .Hand over given.	Night staff rang out of hours doctor at 21:15 .But they received call back from the doctor at 05:20 AM (22/07/24).Patient's BM in early morning was 5.9 .Out of hours doctor advised to inform the duty doctor to review and prescribe . Informed duty doctor regarding the incident in the morning Doctor reviewed and prescribed insulin in the system one Said sorry to the patient regarding missed medication administration . Informed ward sister regarding the incident .	Having checked the notes relating to this incident, I can see that all correct actions were taken. The patient's blood sugar was checked, and an apology was made. This was a clerking error, which was quickly discovered by the nurse. Out of hours doctor was contacted for advice.	Clerking Doctor to double check when prescribing medication for new admission on SystmOne.	Closed
GHC73221	22/07/2024	22/07/2024	18:40	The Vale Hospital	Vale Hosp- Peak View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Stock balance recording errors / discrepancies	Oxycodone	Yes	3.75 mg/mls	3.75 mg/mls	Oral		Myself and one of the ward sisters were preparing a controlled medication from the controlled drug cupboard. We calculated the amount of liquid that should of been remaining, this was double checked using the measurement ruler and it had shown that there was less liquid in the two bottles that were open in comparison to the CD book. The CD book recordings showed that there should of been 280.5 mls, when this was checked against the measurement ruler it showed 265.0mls, we understood this was 15.5mls less that what was evidenced in the CD book.	We corrected the total amount in the CD book to what the measurements were shown against the measurement ruler which was 265.0mls,and agreed a datix must be reported.	Incident reviewed. Bungs for the medication bottles have been ordered to assist in more accurate dispensing of liquid medication. The documentation in the CD book correcting the loss was also reviewed and staff spoken about recording corrections as separate entries and not including them with named patient dispensed medication. The ward pharmacist will be contacted to correct the controlled drugs book when next on the ward	Use of bungs for liquid medication. Correct documentation of liquids has been discussed with staff Ward pharmacist aware.	Closed
GHC73236	23/07/2024	22/07/2024	16:00	ICT	ICT Cotswold North DN	Nursing / residential home	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Drug administration omitted / delayed	Administration	Enoxaparin	No					Patient discharged to home from Care Home (respite care) and enoxaparin and chart not sent with her. Not able to give.	Called Care Home who confirmed that it was not sent with her. Discussed with GP who advised that if someone can collect the drug and chart, it is okay to have the last dose the following day. Daughter will collect and get back to patient by 10am.	Thank you for reporting this incident Actions taken appropriate to ensure patient was reviewed by clinician to maintain safety and obtain medications for administration the next day	Review of hospital discharging procedure	Closed
GHC73279	23/07/2024	23/07/2024	19:15	ICT	ICT Chelt St Paul's DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Other (unlisted)	Yes	22 Units	Yes	Subcutaneous	Subcutaneous	Evening Visit For Insulin. Pt Last Visit Of Shift Due To Covid Status- PEE Worn. On Visit, Pt Had Completed BGL Prior To Visit, Blue Evening Drug Chart Last Signed 22nd July, And Was Chart Needed To Be Completed For Evening Visit, Administered As Prescribed Per Chart And Paper Documentation Completed. Digital Documentation Completed With In Car To Limit Exposure Duration, On Going To Complete Care Plan Discovered Care Plan Had Already Been Completed, And Morning One Was Not Completed, Appears That Visiting Staff Member Had Recorded AM visit On PM Care Plan. Unable To Go Back Into Property To Check Morning Chart As No Spare FFP3 Mask. Liaised With Late Lead For Guidance- Advised Likely To Be Error with Documentation, But If Not Patient Received Lower Dose And Sugars Were Stable. To Complete Documentation And Speak To Manager Tomorrow To	Phoned Late Lead Jess For Guidance- Though To Be Documentation Error, But If Medication Error Dose Lower Than Prescribed. Visit Documentation Completed Request For Next Visiting Staff Member To Take Photo Of Both Drug Charts Tommorow Morning To Confirm Dose Signed For. Datix Completed Once Home To Speak To Manager In The Morning (24th July 2024).	reviewed notes and images. documentation error occurred. DOC conversation held with patient at time of incident and identifiable in notes.	staff review of documentation requested from clinician involved and written reflection requested.	Closed
GHC73294	24/07/2024	23/07/2024	13:00	Long Term Conditions	Cardiac Rehabilitation Service	GP	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Information / advice to patient not given / wrong	Information / advice to patients	Clopidogrel	No					Call made to patient to complete a phase III follow up call. Patient informed me he had had a loose stools for a while. Bloods, stool samples taken at the surgery. As loose stools persisted GP advised patient to with hold anti platelet therapy-Clopidogrel, GP planned to review in a week.	Call made to GP surgery to explain I was concerned about with holding anti platelet therapy, if Clopidogrel was to be held I advised patient should be switched to an alternative antiplatelet. I advised GP Lansoprazole can often cause loose stools and it may be worth with holding Lansoprazole first to see if this helps. GP agreed with plan, GP to Contact patient and advised him to continue with Clopidogrel and hold Lansoprazole.	All appropriate action taken -cardiologist contacted, GP surgery contacted and discussed with GP.	Any alteration to antiplatelet therapy should be discussed with cardiologist first. To be shared with team at team meeting	Closed
GHC73372	25/07/2024	16/07/2024	23:59	CYPS/PH Community Specialist	CYPS/PH- Children Complex Care	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Preparation by administering clinician(s)	Levothyroxine	No					Levothyroxine medicine label did not state when or how often to give the medication	Omitted administration of drug and informed parent	Thank you for reporting this and for correctly following the medication policies and procedures	All policies followed	Closed
GHC73374	25/07/2024	25/07/2024	13:45	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong route	Administration	Dexamethasone	Yes	3.3mg	3.3mg	Intramuscular	Subcutaneous	New patient assessment for end of life care and syringe driver replenishment and steroid injection. Sub cut Dexamethasone 3.3mg given in error as IM injection to left deltoid due to misreading drug chart. Ampoule checked at the time to clarify if could be given IM and it was written that it could on the ampoule. Small bruise caused at site of injection and some slight discomfort reported by patient. Cold pack put onto area.	Small bruise caused at site of injection and some slight discomfort /aching reported by patient. Cold pack put onto area. No any other reports of feeling otherwise unwell from the injection. Incident immediately reported to CLinical Lead who advised seek advice from Palliative Care Nurse who had been involved in patient care during hospital stay up till yesterday. PCN advised it was a small dose and giving IM would not cause the patient any harm. Clinical Lead advise medications management learning, Reflection and clinical supervision with line manager on next shift.	Discussed with staff member straight after incident Open and honest about error- staff member unwell and needed time away from work. Human error mistake - patient informed of error and no harm caused	Staff member needed some time away from work On return has spent some time shadowing to rebuild confidence	Closed
GHC73400	26/07/2024	10/06/2024	12:00	ICT	Reablement Gloucester	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Prescribing	Metformin	No					Patient had been discharged home in the morning. When going through the discharge summary, a number of errors were found. 1. Metformin listed as capsules and already at home but patient taking liquid form only. Was stopped in hospital but reinstated on discharge. 2. Salbutamol listed but has not been taken for 2 years. 3. Loparamide listed twice. Once three times daily and secondly, 2 tablets every six hours. Medication packet stated 1 - 2 tablets fours times a day PRN. Discharge summary had not been sent to GP	Discharge summary taken to GP surgery and discussed issues with receptionist. Summary was taken and scanned on to the system. Issues with medication flagged up and GP called back within 2 hours to give advice and instructions on what to do with the medication issues.	All appropriate actions taken at time of incident.	Highlighted case to Kizzie Jacobs - Medicines Optimisation Pharmacist and Research & Development Pharmacy Lead , who is looking into some of the problems occurring with medication on discharge.	Closed
GHC73404	26/07/2024	26/07/2024	10:30	ICT	ICT Forest North DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Medication breakages / spoilage	Preparation by administering clinician(s)	Metoclopramide	No					Whilst replenishing syringe driver and taking the top off the Metoclopramide ampule, ampule cracked down the side and medication leaked from the side of the ampule. Ampule discarded as medication lost.	- Ampule of medication discarded in sharps bin. - Stock sheet updated to show that ampule had been discarded. - New ampule used to draw up medication for syringe driver. - Datix completed.	- Incident review - No harm caused - Other ampoules from same batch used so not a batch concerns - isolated incident - correct actions taken	Thank you for reporting this - no further learning identified	Closed
GHC73440	27/07/2024	26/07/2024	20:00	Charlton Lane Hospital	Charlton Lane- Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Ordering, collection or delivery	Sodium bicarbonate	No					sodium bicarbonate ear drops 5% were ordered on Wednesday 24th at 20:33 for patient. However, still not received and patient could not be given her prescribed dose	Medication recorded as not available. Email requesting the medication again.	Medication received and continued administration	Staff to ensure they stock check regularly and order medication in a timely manner	Closed
GHC73452	27/07/2024	27/07/2024	09:30	Wotton Lawn Hospital	Wotton Lawn- Dean Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Ferrous sulfate	Yes	200mg		Oral		Medication administered at the wrong time 12pm medication of folic acid and ferrous sulfate administered during the 8am medication round informed duty doctor staff apologised to the patient		Discussion with senior nurse around medication administration and reflective piece provided	Thorough checking of medication and minimising distractions whilst administering medication	Closed
										Wrong time / frequency	Administration	Folic acid	Yes	5mg		Oral						
GHC73458	27/07/2024	27/07/2024	10:00	Cirencester & Fairfrd Hospital	Ciren Hosp- Windrush Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Methenamine	Yes	1000mg		Oral		When the nurse on duty was about to do drug round , found the meds was signed for this evening dose, and query been given yesterday evening .Meaning the patient had two doses.	The nurse on duty informed the ward sister and also informed informed the ward Dr . To this the Dr advised to omit the morning dose . I went to the patient and apologised about the drug error and also did full sets on Observation .	Having checked the paper patient notes and the SystmOne patient record, it is clear that the patient arrived on the ward during the evening with a paper medication administration chart from the acute hospital. This was used to administer his evening medication. When the RN for night shift came on duty, she administered the medication again from the paper chart - but on the incorrect date. This meant that the medication was administered twice. The doctor was informed, and the drug was ommitted the following morning. The patient received an apology.	There is wider learning applicable here - the date/time columns on the paper medication administration chart from the acute trust do not fall below one another, so for the medication in question - the prescription for the next day fell immediately below the previous day for other medications prescribed. We will ensure that we hold some clinical supervision sessions on the ward around the use of paper medication charts, and double checking dates, and against SystmOne record. I will also inform the Temp Staffing Team, as a bank nurse was involved in this incident.	Closed
GHC73462	27/07/2024	27/07/2024	09:30	Wotton Lawn Hospital	Wotton Lawn- Dean Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Quetiapine	Yes	1200mg		Oral		Patient reported to staff that they had taken medication already Staff continued to prompt and ask further questions Patient reported their friend visited the previous day and bought in medication and it was in her bag Staff searched her bag and found medication tablets Patient reported taking 1 quetiapine tablet the previous evening, then accepting the evening dose of the quetiapine from the night staff, then took another 1 quetiapine tablet in the morning Patient reported taking propanolol tablets, in which the packet was found on the bed side table, 2 tablets were missing	Physical observations completed Duty dr contacted Advised to go to GRH Went to GRH, patient refused all treatment and returned Duty dr contacted and plan made to monitor presentation and physical observations Non contact observations completed initially due to patient refusing	Communication to ward staff to be more vigilant when visitors are attending the ward to ensure they do not pass medication to our patients	Communication to ward staff to be more vigilant when visitors are attending the ward to ensure they do not pass medication to our patients	Closed
										Wrong quantity	Administration	Propranolol	Yes	80mg		Oral						
GHC73503	28/07/2024	26/07/2024	14:00	ICT	ICT Forest South DN	Nursing / residential home	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Glycopyrronium bromide	No					Attended to perform stock check on anticipatory medications in nursing home for residential patient Patient was prescribed by NHS 111/Out of hours 06/07/24 5 x morphine sulphate 10mg/1ml ampoules(all accounted for on stock count) 5 x midazolam 10mg/2ml ampoules (all accounted for on stock count) 5 x levomepromazine 25mg/1ml ampoules (4 in box on stock count) 5 x glycopyrronium bromide 200mcg/1ml ampoules (unable to check as 4 vials in secure cupboard but no patient name or box available) I also noted that there was 1 x levomepromazine vial that had been used and unaccounted for. Rodley House had no evidence to say who administered the stat dose.	Advised nurse in charge and senior health care assistant at Nursing Home Discussed with Community Nursing Lead Datix to be completed	05/08/2024 - Community Nursing Lead - Incident & notes reviewed - Contact made with care home manager for further investigation around missing medications. - Missing medications identified and accounted for. - Care home manager has arranged meetings with staff involved and process put in place to avoid future confusion. - Please refer to attached email for assurance of actions taken and process put in place by care home manager	Thank you for your report. This has been discussed with the care home manager and missing medication identified. Assurance received that this has been addressed and process in place at care home to avoid future similar incidents	Closed
										Missing medication	Stock balance recording errors / discrepancies	Levomepromazine	No									
GHC73567	29/07/2024	21/07/2023	10:00	Recovery	Recovery Forest	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Prescribing	Flupentixol decanoate	Yes	100mg every 4 weeks	200mg every 4 weeks	Intramuscular	Intramuscular	A drug chart was rewritten in December 2023. The patient was previously prescribed Flupenthixol Decanoate 200mg IM every 4 weeks. At one point he was having 100mg every 2 weeks and dose had been moved across to a 4 weekly regime. The card was originally written as Flupenthixol Decanoate 100mg every 2 weeks which was later changed to 4 weeks but dose not amended. The RiO progress note had recorded that Flupenthixol Decanoate 100mg every 4 weeks was administer in November 2023 which was an error as patient was then given correct dose of 200mg. There was a recording error in the notes by care coordinator and when drug chart written by the medic dose was wrongly noted. The incident was only discovered on 26/7/24 following routine review of caseload notes and progress for people seen less frequently.	Discussion with care coordinator who has no current concerns for patient or deterioration in mental state. Patient offered clinic apt where he will be reviewed and informed of the error.	Medical and care coordinator review completed.	Discussed at MDT to raise awareness.	Closed
GHC73589	29/07/2024	26/07/2024	10:00	Complex Care at Home	Complex Care at Home Glos	Care agencies (home care)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Drug administration omitted / delayed	Administration	Buprenorphine	No					Analgesia patch not changed which was due to be changed on 23rd July. Patient requires prompting which was due to be actioned by carers.	Prompted patient to change the patch and contacted care agency to make them aware medication prompt not completed	Review of patient records and incidence. All actions taken by reported appropriate. Incidence raised followed up. Discussed with adult social care and care package reviewed. No further actions.	All actions taken by reported appropriate - no further actions.	Closed

GHC73659	31/07/2024	26/07/2024	16:30	ICT	ICT Chelt Peripheral DN	GP	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Prescribing	Morphine	No					Collected End of Life Medication prescription chart from GP practice for patient. Controlled drug prescribed ranges unacceptable and unsafe Syringe driver medication prescribed as: Morphine prescribed range of 5mg - 100mg Midazolam prescribed 5mg - 60mg Patients symptoms were well managed at 10mg Morphine and 10mg Midazolam via syringe driver with very few breakthrough doses required and current prescription chart had a range of 5mg to 20mg of both medications so scope for community nurses to increase following assessment of patient if needed	Medication chart not left at patients house Patient had sufficient medication prescribed on existing medication chart to ensure that his symptoms at End of life were managed well			Being Reviewed
										Wrong / unclear dose or strength	Prescribing	Midazolam	No									
GHC73752	01/08/2024	01/08/2024	13:45	NTQ management	Outreach Vaccination Team	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Monitoring / follow-up of medicine use	Diphtheria + Tetanus + Poliomyelitis vaccine	Yes	0.5ml	yes	Intramuscular		I administered Revaxis IM injection to a patient today and noticed when inputting the vaccine onto the patients record that the expiry date was 07-2024 (which was yesterday). The patient was made aware of this at the time and I reassured them that the vaccination they had received would still be effective.	see above	Clinical Lead for Nursing, Therapy and Quality Projects. Incident form submitted to SW Immunisation Clinical Advice and Response Service (ICARS). GHC Chief Pharmacist Informed. Addition x2 vaccines with expiry date of 31/07/24 isolated for disposal.	Staff to check expiry date of vaccines when packing cool boxes for transporting vaccines to session. Staff to check vaccine expiry date with another clinician before administering a vaccine and to be mindful of the date of the session. Staff will be reminded of learning above through weekly newsletter updates, team meetings and clinical supervision.	Closed
GHC73801	02/08/2024	23/07/2024	22:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Other (unlisted)	No					During the July missed dose audit, 3 missed doses were identified during the 22:00 medication round.	Nurse responsible has been contacted and a reflection has been requested within 7 working days.	Reflection received from nurse indicating learning.	No further lessons identified	Closed
										Drug chart errors - not signed, recording, other	Administration	Melatonin	No									
										Drug chart errors - not signed, recording, other	Administration	Mirtazapine	No									
GHC73816	02/08/2024	26/07/2024	16:00	Crisis Resolution Home Treatmt	CRHT Cots & Vale	Pharmacy-provider	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Ordering, collection or delivery	Zopiclone	No					Pharmacy sent up some Zopiclone for a patient however before giving to the patient it was noted how the medication was cut by pharmacy we were unable to identify what the medication was on the packet. Due to this we were unable to confirm it was Zopiclone, so the Medication wasnt given to the patient and email sent to pharmacy regarding this.	Medication wasnt given to the patient. Emailed pharmacy to explain the situation and ask for them to send more. Dr wrote FP10 for x2 Zopiclone to ensure that the patient had medication.	Discussion with Team Manager. Staff followed process of storing and checking medication on delivery from pharmacy. Noted unable to identify medication. Pharmacy contacted to rectify the issue. Further medication obtained which was identifiable. Medication able to be delivered to the named individual.	No lessons learnt staff diligently followed process and took relevant action.	Closed
GHC73868	03/08/2024	03/08/2024	12:00	Charlton Lane Hospital	Charlton Lane-Chestnut Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Ordering, collection or delivery	Colecalciferol	No					colecalciferol tablet 400 units available in ward 400 units not given as it was presumed unavailable	Contacted pharmacy to enquire about medication who stated it was being queried with the prescriber to confirm if it was 4000 units, staff confirmed it was 400 units and they directed staff to the ward stock. The medication is not administered.	The actions taken were correct for the incident it was just took longer than was needed.	Staff reminded to highlight if medication is not given and check with pharmacy.	Closed
GHC73913	04/08/2024	04/08/2024	12:00	ICT	ICT Chelt St Paul's DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Monitoring / follow-up of medicine use	Insulin aspart	Yes	9 units	9 units	Subcutaneous	Subcutaneous	Patient has twice daily supervision of insulin but no insulin visit yesterday evening. Identified when nurse attended today for AM insulin and patient and husband stated they were unhappy about the missed visit. They did not call in to nursing team. Patient did self administer insulin	-Visiting nurse reported to myself shift lead - Reported to band 6 in charge of case load - Visiting nurse apologised for missed visit - check ongoing visits are booked - Datix	16/9/24 Visiting nurse to complete a reflection on missed pm visit booking. Specialist nurse referred to our diabetic nurse link. No harm to patient.	16/9/24 Staff to ensure when they outcome that all onward visits are booked & escalate if any concerns. Team time also discussed on-going visits with teams.	Closed
GHC73996	05/08/2024	05/08/2024	17:30	Charlton Lane Hospital	Charlton Lane-Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Metformin	No					Patient prescribed Metformin liquid for type 2 diabetes. medication not available nor was in store on other wards , therefore unable to administrate to patient, which held consequences for his diabetic control	went to other wards to see if in stock there none held in stock cupboard or emergency stock cupboard. explained to patient that I was able to give medication to him as not available	Metformin found in the fridge - no supply issue	Staff to ensure they undertake a comprehensive search of the stock to ensure critical medication administered	Closed
GHC74004	05/08/2024	05/08/2024	19:05	Montpellier Secure Inpatients	Montpellier Low Secure Unit	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Olanzapine	Yes	10mg	5mg	Oral	Oral	Medication error where patient was given 10mg of olanzapine which patient was on up until yesterday instead of planned 5mg olanzapine and 5mg aripiprazole.	Duty Dr was contacted who suspended both planned new prescribed medication, to delay cross taper by 24 hours. Patient was informed and apology was tendered. Staff offered patient physical obs. check but he declined, stated he is fine.	No further action required	Issues with communication resolved	Closed
GHC74124	08/08/2024	07/08/2024	07:53	Wotton Lawn Hospital	Wotton Lawn-Abbey Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Lorazepam	Yes	1mg	1mg	Oral	Oral	Staff member reviewing PRN usage noticed PRN lorazepam administered 07/08/24 exceeded indicated max dose in 24hrs by 2xdoses.	Medical team informed Contacted TempStaff clinical lead as staff member involved is agency	Liaised with TempStaff - agency nurse completed reflective piece and undergoing additional training from agency	none	Closed
GHC74125	08/08/2024	07/08/2024	17:00	Forest of Dean Hospital	FoD Hosp- OPD	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Controlled stationary (medication related)	None (no harm caused by the incident)	Missing controlled stationary	Controlled stationary							At end of clinic. Prescription pad unable to be located	Patient contacted by consultant to locate prescription pad. Pad collected by member of staff, and returned to OPD. No prescriptions missing.	GHFT Consultant had been given prescription pad for their clinic as per policy. At the end of the clinic nursing staff went to check and lock away the pad but it couldn't be found. The consultant was still in the clinic room but couldn't locate it. They had only completed one prescription given to a patient with a blood form and some other information. Patient was phoned in case they had inadvertently picked up the pad, which they had. A member of the nursing team lived near the patient. It was arranged they they would call round and collect the pad. The pad was checked, all prescriptions, and confirmed none were missing. Pad returned and locked away in the drug cupboard, Consultant informed that no prescriptions were missing. Consultant also logged Datix on GHFT system.	Process for managing prescription pads followed and alerted staff to the issue. Prescription located quickly and all sheets accounted for. Nursing staff went above and beyond to collect the pad as soon as the error was noted. Consultant to review management of prescription pad whilst in their possession ie keep pad away from patient forms once prescription has been completed etc	Closed
GHC74140	08/08/2024	07/08/2024	08:45	ICT	Reablement Forest	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Monitoring / follow-up of medicine use	Doxycycline	No					Whole blister pack missing (see list of meds included in blister pack), patient came home with 2 blister packs from the hospital last week, one had finished but staff could not find the second. Staff concerned patient could have taken an overdose. Should have been a dose for yesterday morning in first blister pack but this was also missing. Patient was displaying symptoms of being unwell, experiencing whole body tremors, feeling dizzy/giddy and had a headache.	Staff phoned GP who advised to phone 999 due to possible overdose. 999 phoned and paramedics attended the property to assess patient. Rehab assistant waited with patient at the property for paramedics and RCO on duty informed. Medication organised with pharmacy by senior.	999 called following instruction from GP due to potential overdose. 16:48 paramedics in attendance, Clinical history and observations gained. conveyed the following to Coleford Medical practice: Patient has been checked over appears well, is not converying to ED Has contacted Pharmacy they have received lots of medication. Paramedic believes it was returned in error Patient denies having taken any, has capacity More medication being dropped off later will continue to receive visits from reablement GP- to plan HV 13/08/24- referral made to ASC for three calls a day to support with ADL's and medication. Douglas at risk of self neglect	No medication error made, medications were returned to Pharmacy and likely this was completed in error. additional script created to ensure patient would be in receipt of needed medication, medication to be delivered to patient home ongoing.	Closed
GHC74149	08/08/2024	08/08/2024	13:30	MIIUs	MIIU- Forest of Dean	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Medication breakages / spoilage	Stock balance recording errors / discrepancies	Morphine	No					When checking the CD drug stock, the morphine sulphate 10mg/ml ampules box lid was loose. 1 ampule was dropped and smashed within its packaging. 2 nurses checking CDs at time, incident witnessed by senior on shift	informed senior on shift. Destroyed ampoule and content as per guidance. Amended CD book and completed datix	Correct processes followed and CD was destroyed appropriately	Nil	Closed
GHC74194	09/08/2024	04/08/2024	06:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Alendronic acid	Yes	70mg		Oral		Weekly Alendronic acid prescribed at 06:00am not administered by night nurse - missed dose.	Early shift identified missed dose and medic represcribed for following morning. Nurse to complete reflection. Handover form updated to remind of weekly dose needing to be administered by night nurse. Discussion with wider nursing team to ensure understanding of administration instructions for Alendronic Acid and ensure effective handover when prescribed to prevent further missed doses	Appropriate actions taken to prevent reoccurrence. Nurse completed reflection.	No further lessons identified.	Closed
GHC74196	09/08/2024	08/08/2024	16:00	Crisis Resolution Home Treatmt	CRHT West Glos	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Ordering, collection or delivery	Lithium carbonate	Yes	400 mg	200 mg	Oral	Oral	Patient R.M has been on lithium reduction regime. Her Lithium was reduced from 600 mg to 400 on 15/07/24. It should have been further reduced to 200 mg on 26/07/24, but this didn't happen and was missed. she continued taking 400 mg until today.	As no CRHTT doctors present today, Recovery team doctor agreed to amend the medication chart. Lithium 200 mg ordered and delivered to patient.	Unfortunate incident where medication dosage was changed on Rio however community prescription chart wasn't amended. Have reviewed our practice and have changed this going forward. Also regular reviews of medication charts at MDT meetings weekly.	To update medication charts in CRHTT when medication dosages are changed.	Closed
GHC74238	10/08/2024	10/08/2024	10:00	ICT	ICT Forest North DN	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Ordering, collection or delivery	Other (unlisted)	No					Diabetic patient discharged home Discharge summary states 14 units Semglee insulin daily Patient had been supplied with Trurapi Insulin Pen not labelled	- discharge summary checked - No mention of Trurapi insulin - Telephone call to ward who confirmed patient is to have Semglee 14 units only and Trurapi had been dispensed in error - Trurapi disposed - patient had supply of correct insulin from pre admission therefore correct insulin administered	S1 record reviewed. Patient discharged with incorrect medication dispensed. Attending nurse performed safe checks and identified error on discharge summary. Ward contacted to confirm correct medication and dose which was safely administered. Ward informed of error	Thank you for your datix and safe medication checks.	Closed
GHC74249	10/08/2024	10/08/2024	15:30	Cirencester & Fairfrd Hospital	Ciren Hosp- Windrush Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Valproic acid	No					New patient admitted from GRH Ward 6B, last night 09/08. No TTOs came with patient , only medication on compliance aid. Patient not able to take his medications as prescribed , as compliance aid not safe to use in the ward. Patient has missed some of his morning dose.	Ward Doctor informed .Pharmacy rang and requested for the medications to be delivered to the ward today. GRH Ward 9B rang , nurse stated , patient was then transferred from ward 9b to Ward 6b ,Windrush rang ward 6B, no reply .SPOA informed of the incident. Nurse in charge apologised to the patient re- medication incident .	All appropriate actions were taken to ensure that the patient received his medication as soon as possible.	Acute Trust must ensure everything is in place to facilitate safe transfer to another care setting.	Closed
GHC74262	11/08/2024	11/08/2024	02:00	Charlton Lane Hospital	Charlton Lane-Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Oxycodone	Yes	1.25mg		Oral		A female patient was in pain and wanted to give oxycodone hydrochloride liquid . When two nurses went to give medicine , it was noticed the previous dosage which was given by early staff was not recorded on patient's own CD book.	Informed management team . Written on patient's own drug book.	Discussed with nurses on shift and retrospectively added to CD book	Staff to ensure they complete all documentation for CD administration to ensure accurate reflection of medications	Closed
GHC74285	11/08/2024	11/08/2024	12:00	ICT	ICT Cotswold South 2 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Other (unlisted)	Yes	As per chart	Yes - correct dose	Subcutaneous	Subcutaneous	Visited patient to give apomorphine pump. Checked chart and instructions before drawing up, patients wife was then speaking to me, I got distracted and I forgot to sign the drug chart.	Medication was given accurately and safely but chart was not signed. Datix completed. Have let nurse visiting tomorrow that pump was done but that I forgot to sign chart.	Notes reviewed - no harm to patient Documentation on system one clear Advised staff member to check chart more carefully	Human error - staff member to ensure charts are signed in future	Closed
GHC74311	12/08/2024	12/08/2024	08:30	Stroud Hospital	Stroud Hosp-Cashes Green Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong / unclear dose or strength	Administration	Losartan	No	100	25	Oral	Oral	A pack of Losartan potassium 100mg was discovered in the patient's bedside locker, some tablets have been taken out of the blister pack. But the patient is on 25mg of Losartan, so there may have been a medication error. Administering 100mg instead of 25mg of Losartan	ACP informed to examine for any imminent danger BP monitored Correct dose administered	Closed as no incident occurred - staff member was able to recall what dose she gave - 25mg not 100mg.	Good practice noted as staff were vigilant in checking meds and raised concern.	Closed
GHC74326	12/08/2024	03/08/2024	13:50	CYPS/CAMHS - Core CAMHS	CAMHS Core	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Prescribing	Olanzapine	No					Patient was admitted to GRH on 3/8/24 because of a medication overdose (with stockpiling of her medication). Medical observations were all normal and no treatment was required. She was reviewed by the Mental Health Liaison Team (MHLT) and discharged back to her therapeutic placement. A prescription was issued for her current medication by the MHLT clinician with medications changed to liquid/oral dispersible forms to reduce the risk of her stockpiling medication in the future. The prescription was based on the psychiatrist's prior clinic letter (and not on the previous prescription). In this the dose of olanzapine was incorrectly written as 25mg rather than 2.5mg, resulting in 25mg olanzapine being dispensed. The patient didn't take the higher dose as the error was noted before the new prescription was started.	The psychiatrist noticed the error in the clinic letter on Monday 5/8/24 when she was due to review the patient in clinic. The patient did not want to attend the appointment, but the psychiatrist contacted the therapeutic placement on 5/8/24 and clarified what the current doses of medication were for the patient. She reissued a new prescription with the correct dose.	Dr Germain to mitigate any potential adverse impact on patient with rectifying correspondence and evaluation of patient. Dr Germain to consider how to review letters with more certainty that they are correct - eg standardised letters that are easier to review.	potential serious impact averted. team aware of risk that the error could have caused serious harm but near-miss	Closed
GHC74337	12/08/2024	06/08/2024	14:00	ICT	ICT Cotswold South 2 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Denosumab	Yes	60mg		Subcutaneous	Subcutaneous	Denosumab 60mg S/C injection given prior to bloods being taken.	GP informed, discussed with Pharmacist and Band 7 informed Apology given to Pt	Notes reviewed, all appropriate action taken. GP informed, apology made to patient, bloods now taken and calcium levels were within the normal range so no harm done to the patient. Note has now been documented to ensure bloods are taken prior to the injection, also states on the drug chart as well.	important to report these incidences so we can prevent errors like this happening again.	Closed
GHC74353	12/08/2024	25/03/2024	16:00	Recovery	Recovery Cheltenham	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong route	Prescribing	Paliperidone	Yes	15mg stat and then 100mg stat	both were correct	Intramuscular	Intramuscular	Depot prescription was written by Cheltenham recovery team for two loading doses of paliperidone. The prescription was incomplete and did not specify the route of administration, which must be the deltoid muscle. both doses were given into the gluteal muscle. Additionally there was no entry by the prescriber in the RIO notes regarding the prescription of paliperidone loading doses or the instructions to administer via the deltoid muscle. doses were administered by the Gloucester team at the request of the Cheltenham team as the c/c was on leave.	the event was noticed 3 weeks after administration. Clinical advice provided by email regarding delayed onset of action of the drug, co-prescribing, and review dates.	Liaison between TM in Gloucester (reviewer) and TM in Cheltenham. Cheltenham TM liaised with prescribing doctor who wrote medication chart, learning point agreed around writing as site is different in loading dose to maintenance and loading doses are less routine than recurrent maintenance doses for CPNs to know without this being clearly specified by prescriber on chart. Patient was advised of the issue and of continuing with oral antipsychotic incidentally still prescribed by his GP (highlighted to TM as CC will need to follow-up on this being stopped in due course). Duty of candour completed by Cheltenham Recovery care team.	Lessons learnt disseminated to prescribing team RE prescriber responsibilities RE documenting routes of administration particularly when initiating depot injections. Reminder made to Gloucester team CPNs of importance of checking when medication card does not stipulate route and are loading doses to check with medic/pharmacist the correct route and get card updated.	Closed
GHC74357	12/08/2024	12/08/2024	18:00	Wotton Lawn Hospital	Wotton Lawn-Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Medication breakages / spoilage	Preparation by administering clinician(s)	Methylphenidate	No					Medikinet 1x10mg was prepared but then accidentally dropped during the dispensing process. The medication was inside a medicines pot but was accidentally struck by the controlled drugs book when it was being filled in.	Reported to nurse in charge, entry placed in patients notes, email sent to pharmacy, this Datix completed.	acknowledged medication waste	medication waste	Closed
GHC74426	14/08/2024	13/08/2024	10:00	ICT	ICT Glos North South DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Insulin lispro	No					Arrived at patients home to admin insulin , patient has x 2 types of insulin, drug chart for the lispro insulin last entered on the 11/8/24 and on the patients system one notes last entered on the 10/8/24	i have telephoned band 6 and she checked system one notes to see if it had been entered any where else, could not find any insulin documentation to say that it had been given and she advised me to administer the lispro insulin	16/8/24 Both staff members involved have been identified, this incident will be discussed with both of them by their B6 leads. If they require any further training this can be organised.	To be discussed with their B6 leads.	Closed
GHC74462	14/08/2024	12/08/2024	11:00	Cirencester & Fairfrd Hospital	Ciren Hosp- Windrush Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Ordering, collection or delivery	Potassium chloride + Sodium chloride	No					I noticed a box of ten bottles of normal saline with 20mmol potassium in the treatment room. The patient label on it was not the patient who was prescribed the medication, but I was aware another patient with the same surname had been prescribed it.	I immediately checked that the patient (CW) had not received the medication and confirmed that only the other patient had (RW). I checked the paper prescription chart for the patient who had received the medication (RW) and it had been correctly administered as per chart. I phoned pharmacy to clarify how we had received the medication with the wrong patient name on it and they sent through the email that the ward had sent which included a medication chart for RW and a fluid prescription chart for CW. I again checked the prescription chart for RW and it was all correct (appears to have been amended after emailing to pharmacy and prior to administering the medication). I have also arranged for the remaining medication to be returned to pharmacy asap and informed them that RW is a patient on our ward as their records showed that he was still at the previous hospital.	Having reviewed this incident, duplicate datix found and responded to	N/A	Closed
GHC74468	14/08/2024	14/08/2024	16:40	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Medication storage issue	Storage	Apixaban	No					I found out that patient was in possession of Apixaban 5mg tablets. There were 4 tablets left. When i asked her how often she takes the tablets she said one tablet once or twice a day depending on how she feels. I asked her if she knew what the tablets were for ,she said its a blood thinner.	I told her that we needed to keep the medication to prevent overdose which she agreed, I asked her if she took any of the tablet and she denied. I checked on her clothing form and 5 Apixaban were clerked in. I informed Consultant who was in Ward and reviewed her. She discussed with her regarding Apixaban and she said its just a blood thinner.	Emailed the ward manager of the Willow Ward as the client was initially admitted at Willow Ward and in their property checked they have written that she has 5 tablets of apixaban in her possession.	Ward manager of the admitting staff was informed that during the patient's admission they wrote in the property form that the client has 5 tablets of apixaban. Willow ward manager will follow up why the tablet was not taken away from the client when they learned that she has those tablet in her possession	Closed
GHC74482	15/08/2024	12/08/2024	10:00	Cirencester & Fairfrd Hospital	Ciren Hosp- Windrush Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Ordering, collection or delivery	Potassium chloride + Sodium chloride	No					IV Prescription chart has been sent to the Pharmacy with the Wrong PAS label. (as both patients have the same Surnames but different first names) Ward Doctor prescribed 2 x 0.9% N. Saline with K+20mmol 1L x 8hrs .	Coordinator has resent the IV prescription chart to the Pharmacy , with the right PAS label, requesting for the IV Fluids .	Although original fluid prescription chart was incorrectly labelled with the wrong patient's details, this was corrected by the Ward Co-Ordinator and discussed with the Ward Doctor. No medication was administered to the wrong patient. The medication administration chart that was sent to Pharmacy did have the correct patient details on it. This was queried by Pharmacy who noticed the discrepancy in named patients. The Fluid Prescription Chart was corrected and resent to Pharmacy. Fluid which was delivered to ward was Normal Saline 1L + Potassium 20 mmols, but this was labelled for incorrect patient. 10 bottles were supplied. Pharmacy were notified. 2 were used to administer to the correct patient. The remaining 8 bottles were quarantined, and collected by Pharmacy. DATIX GHC74462 relates to same incident.	Although original fluid prescription chart was incorrectly labelled with the wrong patient's details, this was corrected by the Ward Co-Ordinator and discussed with the Ward Doctor. No medication was administered to the wrong patient. The medication administration chart that was sent to Pharmacy did have the correct patient details on it. This was queried by Pharmacy who noticed the discrepancy in named patients. The Fluid Prescription Chart was corrected and resent to Pharmacy. Fluid which was delivered to ward was Normal Saline 1L + Potassium 20 mmols, but this was labelled for incorrect patient. 10 bottles were supplied. Pharmacy were notified. 2 were used to administer to the correct patient. The remaining 8 bottles were quarantined, and collected by Pharmacy. DATIX GHC74462 relates to same incident.	Closed
GHC74566	16/08/2024	31/07/2024	12:00	ADHD & ASC Countywide	ADHD Adults Team	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Controlled stationary (medication related)	None (no harm caused by the incident)	Supply issue	Ordering, collection or delivery	Methylphenidate	No					Prescription of Medikinet XL sent 1st class recorded and failed to arrive.	Staff not aware for several days when reported by the patient that it had not arrived.	Pharmacy informed and pX re written	E-prescribing is needed	Closed
GHC74623	18/08/2024	18/08/2024	08:35	ICT	ICT Stroud Cotswolds DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Insulin glargine	Yes	44 Units	45 Units	Subcutaneous	Subcutaneous	Severn Health Team patient - Daily visit to patient for insulin administration. New Toujeo pen started today, patient insulin chart states 45 units of Toujeo however, insulin pen (toujeo doublestar) only goes up in increments of 2 units so unable to administer 45 units - 44 units administered. All new pens within the fridge are the toujeo double star where as previous pen was toujeo solo star. Apologised and explained the reason for the situation to the patient.	44 Units of Toujeo administered and documented on insulin chart. Apologised to patient. Safety netted patient and advised to monitor for signs of a hypo.	Drug chart has been re written and no harm caused to patient	Staff to ensure that charts are written correctly prior to taking chart to patient property. GP to ensure that charts are correct with insulin pen types	Closed
GHC74626	18/08/2024	12/08/2024	09:20	ICT	ICT Cotswold South 2 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Monitoring / follow-up of medicine use	Other (unlisted)	No					Pen checked by DN prior to administration ascertain when last administered dose - pen indicated that last administration 50 hours, 3 minutes and 20 seconds ago indicating a missed dose on 11/8/24	Patient self administering insulin Supported by DN team twice a week during transition of new insulin At time of assessment DN did not immediately raise this with patient as she becomes very anxious, email sent nephew to update him - DN will increase visits to 3 times a week for closer monitoring of insulin administration Surgery updated of events Patient closely supported by GP surgery regarding insulin dose and increase of insulin	Patient self administering Tresiba insulin. Visited by community nurses three times a week to check and support patient with administering of insulin. During this monitoring on the 12th August it was noted that there was a delay in the Tresiba being given by the patient. Tresiba should be given within 42hrs however the pen highlighted that there was a 8hr delay. Community nurse highlighted this with family member as patient can become very anxious.	Update given to community nursing team to be made aware that patient be delay giving her insulin - some prompts on this required No harm came to patient however near miss due to risk of blood glucose levels increasing if insulin not given in a timely manner	Closed
GHC74688	19/08/2024	15/08/2024	12:00	ICT	ICT Chelt Peripheral DN	Other organisation (please specify)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Information / advice to patient not given / wrong	Monitoring / follow-up of medicine use	Oxycodone	Yes	na		Unknown		- Went to patients home to collect Syringe Driver -Driver still in the box, and left on -Family left the driver to run out by putting contents into mug -No toolbox left in property	- Carefully removed Syringe Driver	Discussed with the nurse who completed the datix the actions taken when at the property	Spoke to the nurse who completed the datix regarding identifying the person affected.	Closed
GHC74702	19/08/2024	19/08/2024	11:30	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Controlled stationary (medication related)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Oxycodone	Yes	22.5MG		Subcutaneous		Visit to replenish syringe driver. Stock sheet for oxycodone 10mg/1ml said 10 amps were received and stock checked in yesterday and sheet showed stock of 10 amps. There were only 5 ampoules available in home.	I checked with husband how much medication he had collected yesterday. he reported that he had collected half the stock as that was all that was available.I phoned pharmacy to check how many ampoules had been dispensed. Pharmacy confirmed that 20 ampoules had been requested on prescription and only 5 ampoules were dispensed and collected by husband yesterday. Chemist confirmed they had a further 15 ampoules waiting for collection today. datix completed re error in stock recording.Note added to stock sheet to highlight that husband reported collecting half the stock.	Human error of miss calculating the amount of stock in property. No ampoules missing - dispensary still had outstanding to dispense. No harm to patient and no delay in care for patient	Remind staff to check when completing a stock check of medication in property to ensure that they have the correct amount. CNL will share this incident at the next Senior Community nurse and DN meeting next week for this to be disseminated within the whole team as a reminder.	Closed
GHC74752	20/08/2024	20/08/2024	12:30	Long Term Conditions	Cardiac Rehabilitation Service	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Information / advice to patients	Bisoprolol	Yes	6.25mg	3.75mg	Oral	Oral	Patient attended clinic following recent discharge from hospital. Patient previously taking Bisoprolol 2.5mg twice a day prior to admission. On discharge patient was reduced to 3.75mg once daily. Patient was given old medication box (2.5mg) on discharge with old label stating twice daily, along with a new box (1.25mg) stating once daily. This resulted in patient taking 6.25mg Bisoprolol a day instead of prescribed dose of 3.75mg.	Explained to patient the change in medication dose since discharge, explained he needs to take 1 tablet of 2.5mg and 1 tablet of 1.25mg -I have crossed out the old label instructions. Advised patient to monitor blood pressure/heart rate at home. Contacted Clinical Pharmacist at GP surgery to update-	Discharging ward at GHT informed and investigating. GP clinical pharmacist informed, and updated prescription and supply 3.75mg Bisoprolol. Clinician following up patient next week to review heart rate and blood pressure as anxious in clinic and feels contributed to his elevated heart rate in clinic.	Datix to be shared at team meeting.	Closed
GHC74753	20/08/2024	20/08/2024	11:00	ICT	ICT Forest North DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Ordering, collection or delivery	Other (unlisted)	No					Routine visit woundcare amputation site Patients partner informed me she had spoken to pharmacist at Mitcheldean surgery and they had advised her that idoflex was a non prescription item and they could not prescribe it and she would have to source it herself and it was expensive Partner managed to buy 3 sachets for £26	Advised partner to discuss with prosthetic nurse in Bristol as they had implemented treatment plan. Spoke to L. Piontek band 7 and she advised to speak to prosthetic nurse and complete datix.	S1 record reviewed. The patient is being cared for by podiatry in Bristol following a below knee amputation the DNs are sharing his care. His partner presented at Mitchledean surgery pharmacy requesting a script for iodoflex which they declined to dispense and asked the partner to buy instead which she did as to was too expensive. The DNs on another occasion also requested a script for the same as per podiatry recommendations and again it was declined. 29/8 E-mail discussion with Laura Bucknall who advised that DN team seek a script from a nurse prescriber o ensure patient receives the appropriate dressings.	Thank you for your datix. DN team to ask nurse prescribers for scripts to take to other chemists.	Closed

GHC74792	21/08/2024	20/08/2024	12:15	Wotton Lawn Hospital	Wotton Lawn- Abbey Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong / unclear dose or strength	Administration	Diazepam	Yes	5mg	2mg	Oral	Oral	Staff member dispensed lunchtime medication for patient. Staff member realised that they had given 5mg diazepam rather than 2mg prescribed in variable dose.	Staff member informed other staff member of error Medical team made aware of medication error and adjustments made to prescription later in the day to account for dosing error. Staff member spoke with patient regarding medication error as per duty of candour Staff member to be requested to complete reflective piece regarding medication error as per medication error protocol	none	none	Closed
GHC74798	21/08/2024	21/08/2024	12:30	ICT	ICT TWNS DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong time / frequency	Administration	Denosumab	Yes	60mg		Subcutaneous		referral from nursing home to give 3 monthly denosumab injection referral not triaged properly medication given to patient, two months early	telephone call to GP fro advise telephone call to band 6 LW telephone call to nursing home in line with duty of candour	Review of notes and incident. Unsure as to why home had requested this to be done, but there was very little triage to confirm why this had been requested. Patient's visit was also moved onto a trainee's ledger when the scope of competance for this injection sits firmly with those nurses who have a pin. The reporting nurse was brave and had a strong sense of Candour to admit error made and to follow through with GP. We have confirmed patients safety and the fact we she has not suffered any long lasting side effects from this. The nurse who made an error has completed a reflection and is aware of the need to fully review what is being asked of her to do and ensure this fits within her scope of competance. To be discussed at team time sessions over the need for us all to be accountable for what is added to our ledgers. Patients family have been apologised to using a duty of candour template and this has been documented on patients notes.	Triage did not occur. It was not identified that a visit was planned for administration in 3 months' time and so not due now. Learnings from AAR meeting: Scope of Practice expectations/ competency is out of date (last review 2019) Allocation of tasks can be difficult if staff competency is not known. Medicines to be administrated according to 'the 6 rights of medicine administration'. Offline use of clinical records needs to be downloaded in advance. Actions as a result of AAR meeting: Ensure Medicines Management is revisited 3 yearly (Currently being updated – relaunch coming soon) Triage to be completed for all referrals. Discussed at all team time meetings + Band 6 meeting agenda for September 2024.	Closed
GHC74799	21/08/2024	20/08/2024	11:00	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Contra-indication in relation to drugs or conditions	Administration	Other (unlisted)	Yes	full pessary		Other	Other	Went to see a patient who was due cream via a pessary - unsure if meant to give so queried with surgery and was awaiting response. Next visiting nurse made aware of this however visiting nurse must not have read any notes as she administered the cream with no reply from surgery - also patient was a new patient, no assessments completed at all.	Chased surgery r.e. cream ?is it needed- eventually surgery replied that it was.	patient's S1 notes reviewed: unclear communications: errors between GP surgery, care home and the community nurses. GP surgery issued the prescription and the DN referral stated a swob needed completing first. Then no further communication from the surgery as to the results of the swob and if the vaginal cream was definately to be administered. This was queried by the DN's but an appt was made for a DN to visit and administer which should not have been made as this caused the patient to have the treatment. Fortunately, after some chasing, the GP surgery confirmed the administration of the cream. The appt for the DN should have been made After the treatment was confirmed.	DN should have read the notes more thoroughly prior to administration and would have noticed that there was a query over this. The DN should not have been allocated a visit until the visit to administer the medication was confirmed by the GP surgery.	Closed
GHC74824	21/08/2024	21/08/2024	18:40	Wotton Lawn Hospital	Wotton Lawn- Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong patient	Administration	Thiamine	Yes	100		Oral		-Service user snatched medication from medication tray of which was not prescribed to them. the patient self administered the medication. Service user was encouraged to spit the medication however she swallowed and said to staff "I am struggling". DMO was informed. Physical observation taken	-Encouraged patient to spit the medication.	policy and procedure followed	N.A	Closed
GHC74866	22/08/2024	22/08/2024	10:30	Wotton Lawn Hospital	Wotton Lawn- Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Disposal	Buprenorphine	Yes	1 patch		Topical		Patient back pain is worse as her morphine patch (controlled drug) has come off. She is not sure when this happened and states she has searched her clothes and bed clothes and cannot find it. Patch last applied on 19/8/24, which should last for 7 days .	contacted the DMO. DMO contacted the Pharmacy . Re-prescribed the patch. Staff searched her clothing's and room with her. Informed her about the controlled drug and need to be mindful about the patch, which she accepted. waiting for the medication to be re prescribed.	Searched ward, bedroom and clothing to no avail.	CD Patch missing	Closed
GHC74903	23/08/2024	23/08/2024	09:20	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong patient	Prescribing	Other (unlisted)	Yes	50mls		Other	Other	Visit for SOS bypassing catheter - after speaking with triage nurse discussed trying bladder washout however when checking drug chart found wrong date of birth on chart - therefore unable to give. Catheter changed	Catheter changed Drug chart removed New drug chart requested from surgery	Reviewed incidents, good practice of checking medication chart	Feedback from Chief Pharmacists - could have accepted verbal confirmation to update date of birth - information to be shared at next leadership meeting and this will then be shared at team times	Closed
GHC74947	23/08/2024	23/08/2024	18:00	ICT	ICT Forest South DN	GP	Medication incidents	Medication incident involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Drug chart errors - not signed, recording, other	Prescribing	Morphine	Yes	2.5mg		Subcutaneous		GP failed to complete chart at time of prescribing JIC medication or did not communicate to the care home staff where chart to be collected from. This resulted in patient unable to have stat doses when needed. When surgery contacted at 16 50 nurse was informed GP would write chart and it could be collected before closing at 1800. When nurse called back at 17 30 to say patient needed stat doses, chart was not written and would be written by the time the family went to collect it. Family returned at 18 20 to say that they had been given a chart with no name on it and when the family went into ask if this was their father's chart they were told yes, but that they could complete the name.	Band 6 on shift contacted who agreed, as a prescriber to come and write the chart and administer stat doses.	02/09/2024 - Community Nursing Lead - Referred in to DN's 23/8/24 for palliative support. - At initial assessment, delay in administering end of life medication as no drug chart available. - Chart then obtained by family but no patient identifiable information on prescription. Returned to surgery but family informed that DN's would complete rest of drug chart. - Prompt escalation by visiting nurse. Now past core hours so would have required OOH GP review but nurse prescriber on duty who visited to complete chart.	Thank you for your report. - Appropriate actions and escalation by community nursing team. - Nurse prescriber on duty who was able to support with completion of drug chart and prevent further delay. - Discussed with team who were aware that if no nurse prescriber on duty then could have utilised verbal order from OOH GP in urgent situation. - Discussed with practice manager who will review with senior partner and GP involved. - This will require follow up by the ICB with regards to internal review from the practice manager and ensuring their systems and processes have been reviewed.	Closed
GHC74962	24/08/2024	23/08/2024	22:00	North Cotswolds Hospital & GMC	NC Hosp- Cotswold View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Monitoring / follow-up of medicine use	Clozapine	No					New admission from home known to suffer with paranoid schizophrenia was admitted to the ward without their clozapine and with no means for the ward to obtain any.	Called 111 to speak with doctor for advice. Doctor asked if we could obtain any clozapine which we could not. Advised to monitor and call 999 if patient becomes delirious or physically deteriorates. Patient checked regularly. Urgent medication order placed with pharmacy with request to call the ward if they cannot deliver today (24/8/24). Ward doctors tasked to advise of situation.	Clozapine had been stopped by community mental health team, day prior to admission to NCH. Clozapine had been removed from patients house by mental health nurse. Patients own GP, had not been informed of this, and was unaware when admitted and clerking patient to NCH. GP rang crisis team the following day for advice and they were advised MH notes, stated Clozapine had been stopped on 22/08/24. Have escalated lack of communication around this with Lead Pharmacist for the trust, who will take it to governance group discussing Clozapine use.	Lack of communication form community mental health team, to patients own GP, regarding stopping of clozapine. This has been escalated.	Closed
GHC74998	25/08/2024	23/08/2024	18:00	The Vale Hospital	Vale Hosp- Peak View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Administration	Yellow soft paraffin	Yes	Nutrison protein plus multifibre	Nutrison protein plus	NG/PEG/PEJ	NG/PEG/PEJ	Patient on PEG feed nutrision protein plus 1,500mls which is commenced every evening at 18.00pm on 23/08/24 Patient accidently administered nutrison protein multifibre by late nurse on duty.	Night nurse on duty, spotted the error and removed bag and changed to correct prescription. Patient apologised to for incident. Ward Sister has asked for temp bank team to contact bank staff nurse involved in incident. Temp staff asked to check medication competencies with bank staff member. Temp staff advised to ask bank staff nurse to complete reflection on error for her revalidation.	Incident reviewed. Ward had 2 patients at the time who required feeding via a PEG. Ward are now ensuring that feed is kept identified and that there are enough supplies. All staff have been asked to check the 5 Rs of medication administration.	All staff have been asked to check the 5 Rs of medication administration. Feed is to be stored clearly labelled and ward to ensure that there is enough stock for the week ahead.	Closed
GHC75092	27/08/2024	26/08/2024	21:15	Wotton Lawn Hospital	Wotton Lawn- Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Use / possession of over-the-counter (OTC) medicine	Ibuprofen	Yes	400		Oral		Patient upon return from leave reported to staff that she has taken a mixed overdose of medications. Staff found : -Three pregabalin 50 mg strip. -One packet of paracetamol 500mg (16 tablets). -One ibuprofen 200mg packet in that three tablets are missing.	Staff confiscated the medications. Taken set of physical observation. DMO was informed and reviewed the patient. ECG has been taken. Physical observation every 04 hrs to monitor serotonin syndrome. Patient was encouraged to attend A&E ,however she decline.She demonstrated an understanding of the risks involving by not attending A &E.	PROCESS FOLLOWED AND PATIENT SUPPORTED	DOMESTIC ABUSIVE RELATIONSHIP BACK AT HOME- GDASS INVOLVED	Closed
										Wrong / unclear dose or strength	Use / possession of over-the-counter (OTC) medicine	Escitalopram	Yes	60		Oral						
										Wrong / unclear dose or strength	Use / possession of over-the-counter (OTC) medicine	Pregabalin	Yes	200		Oral						
GHC75109	27/08/2024	24/08/2024	14:30	MiiUs	MIIU- Stroud Hosp	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Contra-indication in relation to drugs or conditions	Prescribing	Methoxyflurane	Yes	4-6 inhalations		Inhalation		penthrox given to a child for pain relief during application of plaster cast for fractured tibia	the following day during discussion with colleagues over how useful this had been for effective pain relief, I was informed that penthrox is not licensed for use in children			Being Reviewed
GHC75119	27/08/2024	22/08/2024	10:25	Recovery Units	MH IP Rehab- Laurel	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Prescribing	Amisulpride	No					It looks like patient had his amisulpride reduced on Thursday 22/8, but this was not confirmed. As such the last dose of amisulpride that patient has had administered was 200mg on 22/8/24 in the morning before the dose change. There is no progress note regarding this medication change. Drs contacted today, requesting that the amisulpride is confirmed, as nursing staff cannot administer unconfirmed medication (they not visible on the administration screen)	Contacted Drs - unable to confirm myself as no RiO progress note stating whether this change in dose was intentional or not	Discussed with doctors with regard to ensuring that any medication changes are communicated with the nursing team and confirmed on RIO.	To ensure that doctors confirm medication on RIO as soon as this is prescribed and to ensure that nursing team are aware of any changes.	Closed
GHC75140	28/08/2024	24/08/2024	08:30	MiiUs	MIIU- Stroud Hosp	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Morphine	Yes	10	yes	Intramuscular	Intramuscular	10mg in 1ml Morphine given IM to pt with acute high level chest pains. Drug and date check completed prior to administration. Entry into drugs book missed until CD drug check completed.		CD audit dates checked & able to identify timeframe of occurrence. Patient & staff involved identified & ledger completed	All staff reminded of the importance & requirement to complete the CD ledger at the time of giving medication	Closed
GHC75161	28/08/2024	28/08/2024	10:10	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong / unclear dose or strength	Administration	Insulin glargine	Yes	unkown	42 units	Subcutaneous	Subcutaneous	while preforming insulin administration as the pen device was withdrawn there was insulin on the skin and some in the tip of the safely needle. I was therefore unsure of the amount of insulin received by the patient.	Dr was emailed, referral centre contacted.	Staff have been reminded of the correct process to follow when priming insulin pens/ needles, and of administration processes. This should avoid any dosage discrepancies in the future.	Staff to continue to follow recommended protocols and procedures for all insulin administration in the future.	Closed
GHC75191	29/08/2024	28/08/2024	09:00	ICT	ICT TWNS OT	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Information / advice to patient not given / wrong	Monitoring / follow-up of medicine use	Nicorandil	Yes	5mg		Oral		Practise facilitator visited patient to do a medication assessment for a member of staff and discovered patient has been taking 2 x 5mg nicorandil. Doctor had stopped the medication on 01/08. Patient was then admitted to hospital and on discharge i completed an initial visit with patient for homefirst on 21/08, Patient had arrived home with no medication or discharge summary, the hospital had contacted the son to ask him to collect. I returned the following morning to complete the medication risk assesment and added Hospital medication to MAR for administration by RA staff, discharge summary stated 2 x 5mg nicorandil to be given AM and PM each day. Practise facilitator also noted Lansoprazole was prescribed by Dr but not on discharge medication.	I have contacted patient Dr surgery and they have confirmed Nicorandil to be stopped and to commence Lansoprazole, surgery have sent lansoprazole script to pharmacy and pharmacy will do an individual box and will include into the weekly dosette they will be delivering from next week.	Review of notes. Well done for noting error, especially post disruption to patients care from linked datix. Due to time delay in investigating this incident, ward were unable to provide details as to the error. Harm amended to that of GHFT, not GHC. For pst to follow up as part of medication themed errors.	No further lessons	Closed
GHC75253	30/08/2024	30/08/2024	11:00	The Vale Hospital	Vale Hosp- Peak View Ward	Pharmacy- provider	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Ordering, collection or delivery	Other (unlisted)	No					Informed by colleague that the feed ordered by ward staff on Tuesday could not be sourced by pharmacy. This meant that two patients who are currently receiving PEG feed would not have enough feed for the weekend and subsequent feeds.	Dietitian contacted and new regime written to reflect the stock of feed that could be obtained. Doctor tasked to prescribe new feed. New feed ordered and pharmacy advised that this is needed before the weekend to ensure that patients do not miss out on feed.	Discussed with team and feed had been ordered in a timely manner, however there was no follow up to see why it had not arrived due to a change in staff. Pharmacist colleague has also identified that communication from Fairview could have been better so has asked Fairview to inform wards of any stock issues going forward so that alternative can be sought.	Staff need to continue to check stock balance for medication, particularly feeds, and contact pharmacy for expected delivery date if it has not arrived. identified that this should take place earlier in the week so any actions can be taken prior to weekend service.	Closed
GHC75256	30/08/2024	30/08/2024	10:30	ICT	ICT Chelt Peripheral DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Prescribing	Insulin glargine	Yes	24 units	yes	Subcutaneous	Subcutaneous	Drug charts stated wrong date of birth for patient, insulin administered yesterday on drug chart that was wrong.	Drug charts taken out of property and to the GP surgery to be corrected	Chart added for admin to scan to datix. utilised chart and documentation training to review error with clinician. written reflection requested from clinician. able to articulate near miss incident and how this case could have proven detrimental in other circumstances. handed to line manager to review at 1:1	Potential impact of locality short staff levels and minimal time allocated to visits inappropriately. allocation SOP in progress	Closed
GHC75312	31/08/2024	31/08/2024	10:00	ICT	ICT Chelt Town Centre DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Insulin glargine	Yes	14 units	14 units	Subcutaneous	Subcutaneous	I visited patient on the 31/08/2024 and noted Drug chart for Insulin not signed yesterday by the staff member that visited on the 30/08/2024. Noted notes on system one showing insulin was given.	Checked notes on system one to ensure insulin given , DATIX completed	10/10/24 No harm to patient as medication was administer however staff to ensure they sign drug chart as legal requirement as well as S1 records. Reflection completed	10/10/24 No harm to patient & all appropriate actions completed for onward care	Closed
GHC75352	01/09/2024	31/08/2024	16:00	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Cyanocobalamin	Yes	1mg		Intramuscular		3 monthly B-12 given 2 months early. Last given on 5/7/2024 appointment stated that B-12 was due today the appointment had been booked and triaged, patient told me when i arrived that she was expecting me next week. i had no signal for the afternoon as out on visits in low reception areas. realised when i got back to the hospital to document that the medication error had occurred.	called lead nurse, who called out of hours GP, she informed me that GP had no concerns about b-12 being given early. lead nurse has informed patients own GP.	Recognition of error identified by RNA post administration NMC guidance demonstrated in openness and transparency of error Escalated to shift lead and discussed with OOH GP - no harm caused to patient	It is the responsibility of the visiting practitioner to review when medication last administered prior to visit, especially when practitioner meeting patient for the first time Patient was not expecting visit should have been a trigger to visiting practitioner Although poor mobile signal and laptop signal patient has a landline that could have been used to contact shift lead for advice prior to administration Escalated to Senior community nurse who manages staff member to be discussed in 121	Closed
GHC75403	02/09/2024	01/09/2024	10:00	Forest of Dean Hospital	FoD Hosp- Woodland View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong / unclear dose or strength	Prescribing	Dalteparin	Yes	15000	12500	Subcutaneous		patient on treatment dose fragmin for PE. Dose adjusted in acute for weight to 12500iu Reviewed at Forest Inpatient Unit at historical weight of 80kg as no up to date weight available. Dose increased to 15000iu. Patient then began actively bleeding from stoma and increased bleeding from fragile area to skin.	Fragmin held for 24hrs Dose reduced back to 12500iu Explained to patient probable cause and apologised.	AAR meeting carried out duty of candour applied and letter sent	as per AAR meeting	Closed
GHC75416	02/09/2024	02/09/2024	11:30	ICT	ICT Forest South DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Parecoxib	Yes	40 mg	40mg	Subcutaneous	Subcutaneous	2/9 Telephone call from Great oaks nurse to advise that whilst at a patient she counted in stock medication of Parecoxib and one ampule is missing. Stock balance sheet indicates 10 amps but only 9 were in stock.	No documentation could be found to indicate how may amps were dispensed. Stock balance first indicated 9 amps then changed to 10. S1 record reviewed and discharge summary dos not indicate how many amps were dispensed.	05/09/24 - Senior Community Nurse - Colleague visited on 26/8/24 to set up syringe driver. - Colleague was going to administer a stat dose of paracoxib as patient reporting pain. - While colleague was preparing injection patient wanted to try oral oxycodone. - Colleague assisted patient taking oral oxycodone and then patient and wife decided not to go ahead with injection paracoxib. - Ampule discarded but stock sheet not amended.	Thank you for your report. Conversation with visiting colleague and team regarding ensuring stock sheets are completed.	Closed
GHC75478	03/09/2024	03/09/2024	13:00	ICT	ICT Forest South DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Medication breakages / spoilage	Preparation by administering clinician(s)	Oxycodone	No					Attended patient for syringe driver replenishment When opening ampoule, whole ampoule broke into pieces and spilled the contents, rendering it unusable	Ampoule safely disposed of, stock level checked and sufficient for next few days	correct action taken when medication ampule broke. Stock checked and enough ampules in property for the following visit. Medication disposed of correctly.	No lessons to be learnt and all appropriate actions taken at time of incident.	Closed
GHC75482	03/09/2024	23/08/2024	09:00	Long Term Conditions	Long Term Conditions Mgnt	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Controlled stationary (medication related)	None (no harm caused by the incident)	Contra-indication in relation to drugs or conditions	Prescribing	Ramipril	Yes	Ramipril 2.5 and Sacubitril / Valsartan 24mgs /26mgs		Oral		Patient was discharged on entresto and Ace Inhibitor these drugs are contraindicated Patient reported feeling dizzy.	Discussed with patients GP and HF team. Ramipril stopped and advised to continue with Entresto Bloods arranged for U+ES	All actions taken by clinician - discussed with Heart Failure Specialist nurse and GP. Ramipril stopped and GP arranged bloods to monitor renal function. Appointment made for patient to be reviewed by Heart Failure Nurse. Gloucestershire Hospitals emailed to highlight medication incident for investigating.	Incident to be shared with responsible organisation for investigating - Gloucestershire hospitals. Share at team meeting.	Closed
GHC75486	03/09/2024	03/09/2024	14:35	ICT	ICT Forest North DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong / unclear dose or strength	Administration	Midazolam	Yes	25mg	2.5mg-5mg	Subcutaneous	Subcutaneous	urgent call out for a stat dose for an EOL patient. Quick briefing from B6 and previous visiting nursing before attending as patient has been difficult to get his pain and agitation under control. On arrival, 3 different prescription charts. A new chart to use tomorrow, which I put to once side. Midazolam stat on 1 prescription chart and oxynorme on another prescription chart. Stat dose of midzaolam 25mg and oxynorm 15mg administered, chart signed and stock checked and accounted for. When I arrived back at base, I went and spoke to B6, when we realised I had administered a syringe driver dose as a stat dose. B6 rang palliative specialist nurse who went spoke to palliative specialist consultant who advise the midazolam will be out of the system within 4 hours.	- B6 rang B7 and explained the situation - B6 rang palliative care nurse who advised she would speak to palliative care specialist consultant - Nurse visited patient and family, to re-check stock, check charts and make sure patient is ok. - Datix events -Re-do my medicine management	S1 record reviewed. 4/9/24 Meeting with nurse involved with incident. Nurse reported on 3/9/24 she was asked to administer a stat dose by the referral centre nurse as an sos call. Patient was agitated on arrival. Nurse attending found 3 drug charts in the property with various medication prescribed on each. No shared care floder in place . Midazolam 20mg had previously been prescribed and therefore she had drawn up 25mg as the patients agitation was not resolved. Drug chart were signed and she came back to base to document notes due to signal. On returning to base she spoke with the RC nurse who questioned the dose of midazolam and it was then the error was identified. Nurse realised she had then administered the syringe driver dose rather than the stat dose.	Thank you for your datix. Medicines management work book revisited and completed. Reflection of event written. Supportive double up for palliative patients & observed syringe driver set up to be planned. AAR investigation meeting planned with team. Syringe driver policy revisited. Several drug charts in the property none were numbered. Drug chart now rewritten. Use of shared care folder.	Closed
GHC75515	04/09/2024	04/09/2024	08:30	ICT	ICT Chelt Town Centre DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Preparation by administering clinician(s)	Phosphate	Yes	5ml and 10mg	5ml and 10mg	Rectal	Rectal	Routine visit to administer bowel care. Upon checking drug chart, the previous nurse added signed for administration of two medications.	Photo taken. Datix completed. Checked S1 to ensure medication was administered as previous visit, as per documentation, it had been.	Reviewed notes corresponding to date of datix to acertain clinician previous visited. chart unclear and does not correlate to the dates specified. requested copy of new chart. discussed with clinician whom carried out care on reported date of signature omission. s1 notes checked and correctly documented.	requirement for correct images and supporting evidence to be attached to datix report for clear investigation.	Closed
GHC75535	04/09/2024	04/09/2024	15:00	Recovery	Recovery Cheltenham	Nursing / residential home	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Clozapine	No					Care home contacted to explain they had no clozapine medication for tonight, but had tomorrows medication. This was following an additional days worth of medication being delivered due to the chemipac having peeled up at the corner. They did not have the additional night times medication worth that was delivered. Missing clozapine.	Pharmacy contacted to arrange emergency collection of chemipac. Home manager will arrange collection of this. Notified home manager of concerns who will be investigating. Contacted Quality Reviewing Officer Contacted manager	Pharmacy advised of missing Clozapine which was delivered	Pharmacy error	Closed
GHC75567	05/09/2024	02/09/2024	09:00	ICT	Reablement Gloucester	GP	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Prescribing	Apixaban	No					Therapist told that the repeat prescription from the pharmacy had not been delivered. After investigation Therapist found that the repeat prescription had not been signed by the GP surgery 13/9/24 - reported by OT patient had not had medications between 29/8/24 3/9/24.	Therapist visited the GP Surgery with the discharge medication list. Receptionist stated that this list was on their computer system. Therapist asked why the order had not gone to the Pharmacist as a Reablement worker had attended the Surgery on the 19/8/24 to ask that the repeat prescription be sent to the pharmacy as the patient had 2 weeks supply from the hospital.	Email practice manager to highlight case. Progression and well being co-oridinator to collate contacts for practice managers within the county. To contact patient safetey team.	To have clear and easy access to practice managers contacts to ensure there is a main point of contact when incidents occur	Closed
										Missing medication	Prescribing	Lansoprazole	No									
										Missing medication	Prescribing	Pregabalin	No									
										Missing medication	Prescribing	Salbutamol	No									
										Missing medication	Prescribing	Atorvastatin	No									
										Missing medication	Prescribing	Colecalciferol	No									
										Missing medication	Prescribing	Dapagliflozin	No									
										Missing medication	Prescribing	Folic acid	No									
										Missing medication	Prescribing	Furosemide	No									

										Missing medication	Prescribing	Amitriptyline	No									
										Missing medication	Prescribing	Fluoxetine	No									
										Missing medication	Prescribing	Mirtazapine	No									
										Missing medication	Prescribing	Thiamine	No									
										Missing medication	Prescribing	Zopiclone	No									
GHC75607	05/09/2024	05/09/2024	13:00	Forest of Dean Hospital	FoD Hosp- Woodland View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Tramadol	Yes	50 mg	50mg	Oral	Oral	patient has his own Tramadol locked in the Patient's own CD cupboard inside the Treatment Room due for 12nn dose of 50mg Capsule thus 2 RNs went to get the medication but found out that the actual stock dose count does not tally on the book stock dose is 25 capsules but on the book it is written 25 missing one capsule	both RNs traced the amount he have on stock from admission and the dose he had from then up to date but appeared correct on the book and on the medication chart on System1 but not the actual stock count called in Ward Manager KW to recheck; checked the cupboard if it has fallen off from the box but none; checked the below the cupboard area but none found; agreed to Datix and to monitor and keep an eye if this happens again	Tramadol dose was given at time of CD weekly check and also required transferring to next page, transferred amount added to next page without including given dose. missing tablet accounted for and matches signed drug chart. book updated to reflect this	Tramadol dose was given at time of CD weekly check and also required transferring to next page, transferred amount added to next page without including given dose. missing tablet accounted for and matches signed drug chart. book updated to reflect this	Closed
GHC75630	06/09/2024	30/08/2024	14:00	Charlton Lane Hospital	Charlton Lane- Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Levofloxacin	No					Patient prescribed levofloxacin tablets on 29/8/24. An order was sent to pharmacy at 4pm, as this was after the pharmacy transport that day it was put on transport to Mulberry ward on 30/8/24. Ward then requested again from pharmacy on 31/8/24 which was dispensed by ward pharmacy team. First dose not given until evening of 31/8/24. When pharmacy technician visited ward on 5/9/24 she found the box that had been sent to the ward on 30/8 in the medication cupboard. Doses on 30/8 evening and 31/8 morning were missed despite stock being available on ward. As this is an antibiotic, ward could have organised for porter to collect from pharmacy on 29/8 and avoid even more missed doses.		Medication order was sent at 12:56 on 29/8 as well again at 16:00 Medication now present in emergency cupboard Staff reminded of promptness of ordering and discussing with medics where doses missed in case prescription should be extended, to also ensure checking medication hasn't already arrived before reordering.	Staff prompted to utilise medication handover form to stop reoccurrence.	Closed
GHC75631	06/09/2024	06/09/2024	10:00	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Other (unlisted)	No					Patient had Humulin I cartridges prescribed and DN saw them in property 30/8 - unable to start medication then as pen device not available. Now pen device available but unable to locate cartridges- searched patients fridge with consent, patient not seen them ?have they been misplaced/thrown. Medication delayed again.	RC DN S.Clarke informed. More medications ordered urgently via email to surgery	appears patient had thrown insulin away advice given to patient about not disposing of medication DSN informed via email regarding delay in care All medication now in property and patient has started new insulin	patient has capacity = if problems persist patient may need lock box for meds	Closed
GHC75651	06/09/2024	09/08/2024	10:30	ICT	ICT Glos North South DN	Pharmacy- community	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Stock balance recording errors / discrepancies	Other (unlisted)	No					Pharmacy had dispensed an extra tablet in dosette box (for this day only) by mistake	Reported to SCN Dosette box taken to Pharmacy who removed the tablet and re-sealed box	I have called the pharmacy and spoke to the manager to inform them of their dispensing mistake. Manager will discuss with the staff member who organises and dispenses the dosette boxes.	Manager will discuss with the staff member who organises and dispenses the dosette boxes.	Closed
GHC75659	06/09/2024	03/09/2024	11:30	ICT	ICT Glos Inner City DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug has expired	Administration	Other (unlisted)	Yes	50 mls		Other	Other	I went to a patient I had not met before to do a catheter instillation. She was very upset because she had lost control of her bowels and the bathroom was a mess. I cleaned up the bathroom and went to look for the catheter instillations. The patient said everything was in the spare room- there was a lot of catheter supplies all over the bed and in drawers. I found optiflo solutions. The patient said the drug chart was in her bedroom by her TV , it was, and optiflo was written up. The patient remained upset as her feet and clothes were dirty, I cleaned her feet and her carer arrived. I said I would flush her catheter and her carer could help change her clothes, she agreed. I had seen on her notes a different catheter instillation had also been used but optiflo was what i found and used one as it was on the chart. I didn't notice till a bit later that it had gone out of date just over a month before.	I didn't realise till a bit later that the optiflo was out of date, I had to return to base for a teaching session so discussed what had happened with a Band 7 manager.	On review of notes this incident was cause by human error. Error discussed with Band 7 Clinical Nursing lead.	Robust checking of dates of all bladder flushes and medication should take place prior to any administration as part of the 5 R's of medication. Completing notes at time of incident may have highlighted out of date bladder flush prior to administration of flush.	Closed
GHC75687	07/09/2024	07/09/2024	08:26	LD Inpatients - Berkeley House	LD Inpatients - Berkeley House	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong time / frequency	Administration	Diazepam	Yes	10mg		Oral		Patient overdosed on prescribed amount of as required medication for anxiety (exceeding maximum amount in 24 hours).	visual observations as patient not allowing physical observations due to unsettled. Informed mental health on-call Informed on call psychiatrist, who informed us to just keep an eye where possible	Incident reviewed and dealt with appropriately at the time the error was made.	The individual nurse who made the error has reflected on the error and had identified strategies to introduce into her own practice to minimise the chance of such an incident occurring again.	Closed
GHC75690	07/09/2024	07/09/2024	09:00	The Vale Hospital	Vale Hosp- Peak View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Administration	Clopidogrel	Yes	75mg		Oral		Medication prescribed for another patient with a similar name was administered. Clopidogrel was administered instead of Apixaban. This error was noted when signing the patient drug chart.	Prescription chart checked against medication administered. Apixaban withheld. Apology made to patient. Reported to other nurses on duty. Reported to the doctor on the ward. Apology made via telephone to daughter. Daughter will let patients husband know. Incident document	Incident reviewed. Nurse apologised to patient and this is documented in notes. All other actions taken by the nurse were appropriate at time of incident. Nurse involved in incident has now left the Trust, but best practice which is for nurse to complete reflection of incident for own learning, and for nurse to repeat 'Administration of medication' competency on care to learn.	Nursing team to remember the importance of checking wrist bands before administering medications, and if wristband is not on patient, then to get a wristband printed. Staff should use other method to check patient if wristband is not present.	Closed
GHC75692	07/09/2024	07/09/2024	09:45	ICT	ICT Chelt St Paul's DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Monitoring / follow-up of medicine use	Metformin	No					Noticed by visiting that medication was still in pot on side that patient uses ? from previous day 6/9/24 - patient unable to confirm but BGL elevated which could reflect this	Medication disposed of and then medication prompted from todays dossette and patient took whilst nurse present.Observations checked.	CB 14/10/24. Patients BGL elevated - possibly due to not taking oral anti-hyperglycaemic oral medication yesterday as found in pot on table. Medication discarded and patient prompted to take todays medication from lock box under supervision.	High priority note added to patients notes to observe patient taking oral medication during nurse visit. BGL elevated for one day - came down within normal range following day.	Closed
GHC75702	07/09/2024	06/09/2024	18:00	Cirencester & Fairfrd Hospital	Ciren Hosp- Windrush Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong patient	Prescribing	Pregabalin	Yes	25mg		Oral		Pharmacist called the ward to query the medications prescribed for the patient (BJ) as there appeared to be some discrepancies with the current medication chart and the patient's previous medication history. On looking into it I found that the paper medication chart that had been sent over from the acute hospital had been for another patient and these medications had accidently been prescribed for the patient (BJ).	I immediately informed the doctor who was covering the ward at the time and she came to review the patient and amend the medication chart. Full explanation and apology given to the patient by myself and the shift nurse. The shift nurse also informed the next of kin of the incident. All vital observations, including blood sugar taken and monitored over a 24hour period. Bloods requested to be taken the following morning.	Advice has been sought from Duty of Candour Lead, and this incident has been discussed with Patient Safety Team. A full apology was given, and documented, to the patient and to his NOK, by the ward doctor, the ward sister, and the registered nurse on duty. The patient's physiological observations were monitored, blood glucose monitored, and bloods were taken following this incident and were reviewed. All remained within stable range, apart from slight raise in CRP which was relevant to clinical presentation, but not to drug administration. Patient was noted to be slightly more sleepy after this incident, but this resolved quickly.	This incident was caused by human error, and highlights the need to check patient identification across documentation to ensure there is no error. The doctor involved has reflected on this incident, and has considered his practice to ensure an incident such as this does not occur in the future.	Closed
										Wrong patient	Prescribing	Levothyroxine	Yes	50mg		Oral						
										Wrong patient	Prescribing	Losartan	Yes	50mg		Oral						
										Wrong patient	Prescribing	Spironolactone	Yes	25mg		Oral						
										Wrong patient	Prescribing	Morphine	Yes	2.5mg		Oral						
GHC75779	08/09/2024	08/09/2024	21:40	District Nursing (ENDS)	ENDNS- Out of Hours DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Monitoring / follow-up of medicine use	Morphine	Yes	30mgs	30mgs	Subcutaneous	Subcutaneous	Visited patient to administer stat dose for pain. Checked patients syringe driver rate stated 0.16 and syringe being used was braun omnifix. There was no syringe driver monitoring chart in home so unable to check this against my findings. I rang shift lead to ask for advice, advised to turn syringe driver off and then back on which I did however it came up with service required. Checked syringe driver and service stated June 2024- I changed and replenished syringe driver.		Reviewed notes Stated on wrong syringe programme on driver. When reviewing syringe driver set up notes - the rate was within limits of using the right syringe. No monitoring chart - palliative patient needed a lot of medication for symptom relief - to prevent delay of care no shared care folder on nurse but all information documented on system 1. Service date overdue - nurse at first visit read that syringe driver service was June 2025	No lessons learnt - capacity in locality limited aswell as staffing numbers	Closed
GHC75780	09/09/2024	07/09/2024	21:00	Forest of Dean Hospital	FoD Hosp- Woodland View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Monitoring / follow-up of medicine use	Sodium valproate	Yes	correct dose	correct dose	Oral	Oral	upon signing in on Systm1 for the nocte meds some 18:00 and 20:00 due meds of several patients were not ticked off some were critical timed meds for seizures	tried to get hold of the Staff Nurse on Day duty responsible to give the meds via FB messenger and replied "I have really have a bad headache, and have since dinner time, that's just getting worse, can't think straight, wouldn't be able to tell you right now. I'll will have to look tomorrow when head hopefully clearer. I certainly wouldn't know without looking" When further inquired for a particular patient who has critical meds for seizures at 18:00, she replied "no not AL the only drug I didnt give was the 9pm one - not 6pm or 8pms, 9pm wasnt for Ash though; Sorry dont remember who it was"	Medical team informed. Training and Development Sister/Ward Sister has had several one to one conversations around medicine management and safe practice and how medication errors can be reduced with best practice and safety measures put in place. Individual concerned in the incident has now completed two supervised drug rounds and medication administration competency has now been signed off. Medicine management modules on Care to Learn have been completed again and personal reflections of medication incident completed. Colleague reminded to escalate any concerns to ward sisters or nurse in charge on incidents which may affect performance during medication administration in order to reduce any potential medication errors.	Do not disturb red tabards advised again to be worn when completing medication rounds to reduce chances of being interrupted during administration of medicines to patients. Safety brief updated as a reminder to wear do not disturb tabards.	Closed
GHC75805	09/09/2024	08/09/2024	19:30	Rapid Response & EONS	Rapid Response	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Adverse / allergic drug reaction (when used as intended)	Administration	Teicoplanin	Yes	1 gram	1 gram	Intravenous	Intravenous	when visiting this patient she tells me the iv antibiotic that she was given last night via a drip went through in a couple of minutes. when she questioned this with the practitioner giving the antibiotic he stated, it was fine and not to worry. she has had multiple iv antibiotics with severe anaphylactic shock in the past. subsequently after the dose was given she suffered severe diarrhoea, LOC, confusion and her husband called 999. she has raised this concern with me as she feels the drug was given much to quickly and had it gone through more slowly she may not have reacted.	i have said to the patient i will raise this with senior staff and will escalate it to be looked into.	Investigation completed by IV therapy matron	Staff to check Medusa prior to administering medication, IV medication update sessions to be arranged for staff run by IV therapy. IV therapy link from RR to be identified for dissemination of medication updates.	Closed
GHC75819	09/09/2024	09/09/2024	14:30	ADHD & ASC Countywide	ADHD Adults Team	Other organisation (please specify)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Pharmacy	Lisdexamfetamine	No					Prescription for Lisdexamfetamine 70mg written on the 2nd September and posted to chosen pharmacy 1st class, signed for delivery. Prescription did not arrive to pharmacy until today (9th September) at 14:09 meaning the patient has had to go 2 days without her medication.	Telephone call to pharmacy to confirm they had not received it. Looked on the post office website to confirm when it was delivered and signed for (coincidentally happened to be 5 minutes after I phoned the pharmacy). Telephone call to patient to apologise.	Patient received their prescription from the nominated pharmacy	Patient received their prescription from the nominated pharmacy, prescriptions by post can be delayed	Closed
GHC75854	10/09/2024	05/09/2024	13:00	ICT	ICT Stroud Cotswolds DN	Self-care	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Morphine	No					Daughter phoned and advised the patient is in pain but a new bottle of oramorph has gone missing - only a dose of 5mls had been used from the bottle. Family have been searching for this but unable to find it. Family have spoken with the carers and they do not know where it is. Daughter has checked with all family members and they do not know where it is. Daughter unsure if the new bottle of oramorph had been put in the recycling and this has now been collected and emptied by the recycling team.	Daughter contacted the GP for an urgent prescription of oramorph. Advised daughter to let us know if the missing bottle of oramorph is found. Urgent visit from DNs was needed as patient was in pain, family did not have the oramorph to administer so a stat dose was requested.	No action taken patients own medication and property. Patient not in pain, no stat dose needed.	None	Closed
GHC75870	10/09/2024	10/09/2024	12:30	ICT	ICT Glos North South DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Other (unlisted)	Yes	74 units	72 units	Subcutaneous	Subcutaneous	I went to a patient to administer insulin. He is on a sliding scale of insulin and I thought it was Monday so I increased the dose by 2 units. When in my car documenting I noticed the person yesterday had written they increased insulin by 2 units the day before.	called home and informed them and asked them to tell patient and apologise from me. Informed Shift lead. Informed GP and was reviewed by diabetic nurse at the practice.	Drug error made when administering insulin - 2 units should not of been increased. Duty of Candour completed, nurse apologised to patient and informed the correct bodies. Patient had a review with the diabetic nurse at the GP surgery. Carers checked BGL more frequently on this day as advised. No harm caused to patient.	Reminded staff about the 6 R's of medication and advised to complete a reflection.	Closed
GHC75937	11/09/2024	10/09/2024	19:51	Wotton Lawn Hospital	Wotton Lawn- Kingsholm Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Promethazine hydrochloride	Yes	150	100	Oral	Oral	Noticed that service user was administered a total dose of 150 mg prn Promethazine in 24 hours while the prescription advice a limit of 100 mg in 24 hours.	Datix being completed Duty of candour: Attempted to talk to service user and offer apology given the medication error; however service user was agitated, pacing around, unable to listen to conversation. Email sent to staff requesting for a self reflection on the medication error. Requested medics for a review following medication error- Although it was difficult to obtain a satisfactory assessment from service user due to elevated mental state; no current concerns/medical interventions advised.	Once identified patient reviewed by ward medics (no further action required medically). Staff member identified, reflective account requested regarding the medication error. Charge nurse has reviewed with staff member and teaching offered around medication administration. Apology offered to patient concerned (however due to level of mania patient not willing to listen to apology). Prescription changed from 25-50mg four times daily to 25-50mg twice daily as a means of reducing risk of any further errors of this nature.	Staff member responded positively to micro-teaching and reflective account. In line with duty of candour apology offered by ward charge nurse.	Closed
GHC75942	11/09/2024	10/09/2024	10:00	ICT	Reablement Gloucester	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Paracetamol	Yes	500 mg x2	2 tablets AM 2 tablets lunch 2 x tablets tea time, 2x tablets evening 2 tablets PM	Oral	Oral	REablement worker noted that Patient had taken morning and lunch time tablets before she had arrived. Reablement worker noted that Patient had taken the teatime and evening tablets at the teatime call.	Reablement worker rang Therapist on the morning of 11/9/24 and reported incident. Therapist contacted the Receptionist of the GP surgery to inform them of this. Therapist followed this up with email informing the surgery of this. 12/9/24 - for reablement lead to chase therapist for more detail around medication patient overdosed on.	All appropriate actions taken at time of event	All appropriate actions taken at time of event	Closed
GHC75956	11/09/2024	11/09/2024	14:00	ICT	ICT Cotswold South 2 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Preparation by administering clinician(s)	Citric acid	Yes	100ml	100ml	Other	Other	went to check prescription chart for bladder washout noticed not been signed for some time so I was unsure if this was correct chart but only chart available with the correct bladder washout patient had told me she had turned away nurse previous week as was past 6pm	signed prescription chart asked my senior nurse if I had to datex or was this an ok not to sign even though I was sure you had to I advised the patient we can arrive anytime from 08.00 to 20.00 hours	- notes reviewed, drug chart was not signed as patient had been refusing bladder washouts.	- non adherence templates should be completed at point of refusal no further learning identified.	Closed
GHC75973	12/09/2024	11/09/2024	21:40	Recovery Units	MH IP Rehab- Laurel	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Lithium	Yes	5mls	10mls	Oral		Medication not enough to give to patient.(Lithium). 10mls prescribed. Medication remaining only 5mls which was administered.	Medication order request sent off to pharmacy.	Discussed with the doctors and agreed that reduced dose would be fine for one dose and to ensure that medication is ordered and delivered promptly. The medication arrived the same day therefore no further doses were missed	Discussions with the nursing team and pharmacy around ensuring that there is always adequate stock of liquid medications in particular.	Closed
GHC75991	12/09/2024	11/09/2024	10:00	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Insulin glargine	Yes	40 units	40 units	Subcutaneous	Subcutaneous	Arrived for BGL monitoring and insulin admin .Pt's husband had requested an early visit due to him having a GP appt . Due to short notice this was not achievable . When I arrived pt and husband just about to get into the car . Husband advised that between the carer and him they had administered the insulin but not checked BGL .	Escalated to Referral Centre .Offered to check BGL husband refused as late for appt . Documented conversation and datix completed .	Notes reviewed. Explanation given to patient that we need more notice if we need to attend early. Husband has in the past given insulin , unsure why he did not check BGL level. Was in a rush and feeling stressed getting to hospital appt. Following day patient was fine ands BGL normal so we can only presume insulin was administered correctly previous day.	Important to report these incidences to protect patients from harm and prevent instances like this happening again.	Closed
GHC76032	12/09/2024	12/09/2024	08:30	ICT	ICT Cotswold South 2 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Ordering, collection or delivery	Insulin glargine	Yes	42 units	42 units	Subcutaneous	Subcutaneous	patient stated neighbour had gone to pharmacy to collect insulin pens, was told by pharmacy no pens there as collected by nurse	contacted surgery to check on when prescriptions last sent. contacted pharmacy to check they didn't have them. had a emergency prescript sent to pharmacy. confirmed with pharmacy received and ready. Patient neighbour phoned and asked if her contact number could be added to patients notes (agreed) patient neighbour phoned and message left to inform prescription ready to be collected. DN to review next visit.	Had historically not collected dossette boxes since August 2024 Was being supported by Frailty team Can see that insulin was requested 4/9/24 Patient was asked 10/9/24 to arrange collection of insulin - this was not completed or followed up Noted on 12/09/24 that no additional stock of insulin in place - emergency order placed and RNA requested collection via neighbour Documentation not entirely clear on situation	Care plan now in place for monthly stock check to avoid patients running out of stock for insulin management RNA completing datix having supervision on datix management to support future submissions	Closed
GHC76074	13/09/2024	10/09/2024	14:00	Wotton Lawn Hospital	Wotton Lawn- Kingsholm Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Medication storage issue	Storage	Oxycodone	No					3-monthly CD check on Kingsholm ward -CD keys not kept on-person, laid on countertop -No entry in CD POM register for oxycodone -Open/already used denaturing kits stored in cupboard -CD order book does not have "received by" line		In light of these omissions / incidents following actions taken: * Email immediately sent to all qualified members of staff to highlight these concerns and demand immediate improvements in practices around management of controlled drugs. * Controlled drug policies and SOPs printed and circulated among staff with instruction to read and sign once understood. * Review of procedures of logging controlled drugs in CD book. * Invitation to pharmacist to attend ward away day to discuss controlled drugs, their handling and storage etc. * Medication lead nurse requested to perform spot-checks of CD book to identify any omissions /errors. * Communication book introduced into clinic for staff to highlight any concerns / issues around medications.	Management of controlled drugs highlighted among qualified staff members and reminders of responsibilities issued.	Closed
GHC76078	13/09/2024	13/09/2024	09:00	ICT	ICT Glos HQR DN	Other organisation (please specify)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Information / advice to patient not given / wrong	Information / advice to patients	Insulin glargine	No					A new insulin has been prescribed to replace current insulin for patient, due to a risk of hypoglycaemia. This has been prescribed following review by diabetic specialist nurse at GP surgery, and discussion with B6. Chart for insulin collected by nurse on wednesday, however unable to commence as insulin was not in home. On thursday staff found new insulin following administration of current insulin. During visit today staff at the home refused for me to commence the new insulin regime as they were not aware of the new regime.	Informed senior nurse. Email sent to GP to advise of this.	Patient was not harmed during this incident as previous insulin was administered. Staff at home were concerned about new regime and did not fully understand that this had been discussed with senior nurses, GP and diabetic specialist nurses. Once staff were informed by GP of new regime new insulin was commenced	Healthcare professionals to communicate changes of medication to staff at care homes and reasoning behind this. Appropriately escalated by visiting nurse within DN team.	Closed
GHC76132	14/09/2024	21/08/2024	22:00	Charlton Lane Hospital	Charlton Lane- Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Paracetamol	No					During the August missed dose audit, a missed dose was identified during the 22:00 medication round.	The nurse who did the missed dose has been contacted and asked to complete a reflection within 7 working days.	Reflection completed by nurse involved demonstrating learning.	No further actions identified	Closed
GHC76133	14/09/2024	23/08/2024	06:00	Charlton Lane Hospital	Charlton Lane- Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Ofloxacin	No					During the August Missed dose Audit, a missed dose was identified during the 06:00 medication round	The nurse who has done the missed dose has been contacted and asked to complete a reflection within 7 working days.	Reflection received from nurse involved demonstrating learning	No further lessons identified	Closed
GHC76193	15/09/2024	15/09/2024	08:15	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Monitoring / follow-up of medicine use	Aspirin	No					Visit to patient for BGL, insulin administration and prompting medication from dossette box. All are kept in locked box with code. I noticed that medication from thursday was still in the dossette box.	I asked patient if she knew why she hadn't taken the medication and whether she had taken any days out of sequence. Patient said she did not know. patient has new stock of dosstete boxes,new box added to locked medication box, to ensure patient will be taking on correct days as start on monday. Records checked and indicate that patient had a missed appointment on thursday, where visit was then later in the day, and there is no record of medication being prompted. datix completed.	Patient had a later appointment this day due to being double booked on the late shift. There is a care plan in place for oral medication prompting however not on appointment ledger. Overall outcome human error.	Now added to reoccurring appointments to prompt medication from dossett box. Reminders re looking at care plans.	Closed
GHC76195	15/09/2024	12/09/2024	14:15	ICT	ICT Cotswold South 2 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Stock balance recording errors / discrepancies	Oxycodone	Yes	35mg	35mg	Subcutaneous		When replenishing syringe driver on 13th September, found that the increased dose of Oxycodone (35mg) was set up yesterday but signed for on old chart which has a maximum dose of 30mg. Stock sheet was also incorrect, with a starting count of 26 instead of 27 ampoules of Oxycodone.	Checked charts and used correct one for the replenishment with 35mg oxycodone. Recounted all ampoules and correct level is in property, note made on stock sheet for correction	Human error around documenting correct dose and stock levels in property. No harm to patient from this incident - clerical error	Discussion at Team Time regarding 6 R's - ensuring that staff have enough time for visit to allow head space and concentration. Home environment quite intense which may be a contributing factor to the clerical error	Closed
GHC76196	15/09/2024	06/09/2024	08:15	ICT	ICT Cotswold South 2 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Ordering, collection or delivery	Insulin degludec	Yes	50iu		Subcutaneous		Visited patient to administer insulin, has a new chart for a change of insulin, old lantus chart was discontinued by practice nurse when new chart was written previous day. No stock of the new insulin was in the property, so unable to administer. There was a note from the visiting nurse the day before telling me to collect it from pharmacy, however this is not policy and family were aware there would be insulin to collect.	Spoke to daughter, who came over and collected insulin so I was able to administer it, about 3 hours later than normal. Call booked to check BGL later that day to ensure ok. Agency nurse was not aware we cannot collect medication so explained this with the rationale.	Well safety netted and organised to arrange collection of new insulin and chart Some delay in administration Patient admitted to hospital 7/9/24 - unrelated to changes in insulin - acute delirium	Pre existing drug charts not to be discontinued until confirmation of new insulin and drug chart in the property Information to be shared at all team times	Closed

GHC76197	15/09/2024	15/09/2024	11:00	Rapid Response & EONS	Rapid Response	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Contra-indication in relation to drugs or conditions	Prescribing	Nitrofurantoin	Yes	100m BD		Oral		Patient started on oral Nitrofurantoin 100mg BD for CAUTI on PGD despite patient known CKD 3 with chronically low eGFR 20'S -Bloods taken and reviewed and antibiotics continues despite eGFR 25. Patient essentially left untreated as Nitrofurantoin will not work with poor renal function and deteriorated overnight.	Patient reviewed the following day and prescribing error discovered. Patient has deteriorated, Nitrofurantoin stopped and remote prescribing for Rapid Response Practitioner on scene to administer IV fluids, Paracetamol and IV Ceftriaxone 2g and admission arranged to CATU as now off legs and unsafe to remain at home. Issue raised with Rapid Response Practitioner who seemed unaware of PGD stating not to be given is eGFR > 45	Emailed the practitioner in question to obtain their version of events and then asked them to write a reflective piece with lessons learnt.	Clinician reflected on this episode of care and he has listed some actions to mitigate the risk of this happening again in the future.	Closed
GHC76205	15/09/2024	10/09/2024	16:29	ICT	ICT Cotswold South 2 DN	GP	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Prescribing	Warfarin	Yes	family continued prior dosing to ensure meds received		Oral		Alerted by HCA on 13th September 2024) to a task on S1 from GP from GP hub to agency nurse regarding INR dosage and next test date. No referral into service for next date and unable to see if family had been informed of dosage. Notes documented 10/9/24 incidental finding that INR request made directly to staff member	Unable to see that the task had been seen and actioned. Normally GP's phone patient or family member and referral centre are contacted. HCA contacted surgery reception and explained that agency nurse should not be tasked and that DN referral centre should be informed of new test appointments, requested surgery contact family and advise of new dosage. Dose had increased by 2.5mg across the week. Daughter confirmed with visiting staff member later in day they had rung. Confirmed appt on ledgers for next test date	Incidental finding of request for INR monitoring Request had been made by surgery via TASK directly to staff member - INR request requested for 6/9/24 Notes reviewed 10/09/24 - INR completed 10/9/24 - Escalated to visiting nurse and completed	Ongoing TASK issues Email sent to surgery to remind them that TASKS should be sent to referral centre only and should not be sent directly to staff members to ensure timely action	Closed
GHC76232	16/09/2024	16/09/2024	09:00	Recovery Units	MH IP Rehab- Honeybourne	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Methylphenidate	Yes	50		Oral	Oral	Whilst completing normal medication round, and signing for regular CD medication staff noticed that there were no signatures present for: 13/09, 14/09, 15/09	Review of patient notes indicate that patient had received medication on time as prescribed. Review of CD's present count of medication correct for expected amount. Patient reviewed and stated that they had medication on time as expected. Staff team notified of expectation of signing of CD medication.	Management and accountable of signing in and out of CD medication given to all staff.	Medication audit continues on the unit.	Closed
GHC76239	16/09/2024	16/09/2024	11:00	Charlton Lane Hospital	Charlton Lane- Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Gabapentin	Yes	100mg		Oral	Oral	During the medication round this morning, the medication was potted up and ticked off as being in the pot including CDs Gabapentin 200mg which equalled 2 tablets, witnessed by two staff members. The pot was then covered, and I made my way to give it to patient AR. He was on his way to the bathroom with the assistance of an HCA. As he was struggling to walk, he was given a seat this was in the door way between bathroom and bedroom. I offered AR his medication while he was seated he was happy to accept. The HCA, who was at a better angle, took the medication to hand it to AR. She poured it into her hand slowly, and it appeared that all the tablets landed in her hand. As AR was taking the medication, I noticed there was only one Gabapentin tablet in the HCA's hand. She confirmed that, to her knowledge, there had only been one tablet.	We searched the area to see if this has fallen, checking ARs PJs in case it had rolled in them. Checked the clinic and all other areas The 100mg gabapentin has not been recovered and the medication notes reflect that medication was partially given.	Documented appropriately	N/A	Closed
GHC76258	16/09/2024	11/09/2024	18:23	Charlton Lane Hospital	Charlton Lane- Chestnut Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug prescribed with known allergy	Prescribing	Codeine	Yes	15mg		Oral		FY1 doctor prescribed codeine in error as it was on the patients list of intolerances. It was verified by pharmacy. 3 doses were given over the next 2 days with nurses missing the intolerance as well. It was recognised by the FY2 on the ward and immediately discontinued.	FY2 noticed the error on 13/09/24 and it was immediately discontinued.	staff reminded of importance of looking at alerts when administrating medications	Look at Alerts to check for allergies	Closed
GHC76262	16/09/2024	16/09/2024	12:30	Assertive Outreach	AOT West	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong method of preparation	Administration	Haloperidol decanoate	No					Patient required a depo, on aspiration blood was found in the syringe drive. Needle was withdrawn immediately, assessed area of administration no adverse reactions identified. Patient was responsive and did not display any discomfort on injury to area.	Needle withdrawn with immediate effect, injection site assessed	correct procedure followed at time of the incident	reflective discussion during MDT around this incident and learning from it	Closed
GHC76309	17/09/2024	11/09/2024	10:00	ICT	ICT Glos North South DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Insulin human	Yes	20 units		Subcutaneous		Insulin administered at incorrect time (to early) due to late administration previous day Insulin appointment left on ledger for normal (AM) allocated time, although morning medications due for prompting Also on RN ledger for (PM) BGL check and insulin administration.	Reported to CNL Reported to GP Reported to RN visiting (PM) and appointment amended for BGL check only Appointment for Evening BGL check Documented in notes	Notes checked. Staff member had amended / created an appointment for later administration although had not cancelled original visit meaning that staff member arrived at normal time. Staff reminded in recent email and team time about the 5 R's of safe medication administration to prevent future near misses and potential drug errors.	Essential to remember the 5 R's of safe medication administration. Ensure that the documentation is correct and notes are checked prior to visiting patient. If amending appointments to ensure that original appointments are cancelled and no duplication of visits has occurred to prevent near misses and potential drug errors.	Closed
GHC76363	18/09/2024	18/09/2024	10:00	Cirencester & Fairfrd Hospital	Ciren Hosp- Coln Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Cyclizine	Yes	150 mg	50 mg	Oral	Oral	alerted by ward doctor that the cyclizine had been prescribed at 150 g TD instead of the correct dose of 50 mg TDs this had been administered once last evening and this morning by the same nurse,	nil adverse effects from the incorrect dose, nurse updated and supported prescription changes, NOK informed	ward doctors both aware of the incident but this was prescribed by a bank dr	nurses also to be awre of the error and to know the correct doses of medication and then check	Closed
GHC76378	18/09/2024	18/09/2024	10:45	ICT	ICT Forest South DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong formulation	Administration	Oxycodone	Yes	25mg Oxycodone	35mg Oxycodone	Subcutaneous	Subcutaneous	Routine visit to replenish daily syringe driver. Medication Stock checked and evident that yesterdays drug calculation was errored and syringe driver replenished under dosed. This was confirmed by myself as the visiting nurse now aware i only used 3 ampules each containing 10mg/m and recollected drawing up 2 and half ampules equalling 25mg in total. Patient required 35mg of Oxycodone but only received 25mg Oxycodone. This was documented on the chart as 35mg Oxycodone. All other medications in the Syringe driver and stock sheets accounted for.	Stock checks of medications. Telephone call to Band 6 for advice. Photos of charts and Syringe label obtained. Verbal Apology to patient and family. Further Face to face meeting with Clinical Lead and Band 6 to reflect and plan the next steps.	30/09/2024 - Community Nursing Lead - Patient was visited for daily syringe driver replenishment - under dose of medication administered. - Same nurse visited the next day and identified error. - Immediate open and honest approach with patient and family and verbal apology given - No harm to patient - no additional stat doses or breakthrough medication required during period of time with lower dose. - Staff member has completed thorough reflection and has identified areas of learning within own practice - Has had debrief / 1:1 with senior nurse and CNL for team - - Reflection and record of conversations uploaded to staff members p file	Genuine human error. Staff member has reflected on incident and identified areas for learning. Open and honest approach throughout. Discussed with head of profession and end of life lead who agree appropriate actions have been taken.	Closed
GHC76396	18/09/2024	18/09/2024	14:50	Wotton Lawn Hospital	Wotton Lawn- Abbey Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Lorazepam	No					14:00 Loraz'- unclear if it has been given as it has not been signed for even though it was Pxd for 14:00. However the Bush Francis Scale had documentation to suggest it has been administered but no time was attached so it made it all very unclear.	Medics advised of the incident and stat medication Pxd and datix completed.	Medication error protocol initiated	none	Closed
GHC76402	18/09/2024	17/09/2024	14:00	ICT	ICT Forest South DN	GP	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Prescribing	Dexamethasone	Yes	10mg	4mg	Oral	Oral	Call into Referral Centre from husband He reported being concerned that he had given wrong some of Oral Dexamethasone, but nurse had helped his confirm dose. He later received a call from surgery to state they were prescribing an alternative form of liquid dexamethasone due to the fact original bottle did not contain a dose, it stated as directed by Palliative Care.	Reviewed patient and symptoms verbally with husband. Discussed sequence of events and confirmed from entry from 15/9/24 that dose should have been 4mg, not 10 mg as husband had given. Spoke to Palliative Care to confirm if anything needed to be done for patient and they escalated to their pharmacy team. Spoke to husband to advise no harm. He was greatful for support given by visiting nurse and the fact she was able to support when he felt unsure of what he should give. Escalated to nurse's line manager as advice given was incorrect.	25/09/2024 - Community Nursing Lead - Patient being seen by DN's daily for syringe driver replenishment for symptom control. Also daily subcut dose of dexamethasone. - Diagnosis of metastatic bowel ca. - Plan from palliative care on 12/9/24 to convert dexamethasone to oral suspension. - Prescription generated by GP on 12/9/24 but non specific directions of "use as directed by palliative care" - no frequency, dose or duration. - Identified on 16/9/24 by another GP who sought clarity from palliative care regarding dosing. New prescription then generated with accurate directions for administration "4mg (10ml) daily". - Initial prescription in house was used for administration causing confusion for patients husband and visiting nurse. - Visiting nurse also in process of replenishing syringe driver and did not thoroughly check dosing on bottle.	- Discussed with visiting nurse. - Thorough reflection completed and learning identified by staff member around ensuring able to offer advice in appropriate environment, ensuring administration guidance is correct and also seeking advice if unsure. - Face to face one to one supervision completed with staff member. - Staff member is also booked on to "Difficult conversations at end of life" training which will support with difficult palliative conversations and support staff members confidence in complex scenarios. - Supervision and reflection have been added to staff members p file - Incomplete prescribing needs to be followed up with surgery and this has been passed to datix team to ensure this is reviewed by the ICB.	Closed
GHC76424	19/09/2024	17/09/2024	20:00	Charlton Lane Hospital	Charlton Lane- Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administered when stopped	Administration	Bendroflumethiazide	Yes	2.5mg	0mg	Oral	Oral	Patient due to go on overnight leave today, however on checking his dosette box it was identified as incorrect. There was a medication in there which has no been suspended. The dosette box had been used on the ward 3 times (over 2 days). The nurse who started using the dosette box has administered all the correct medications, however has used a dosette box which is incorrect. The nurse who administered the medications the following morning, potentially administered the suspended medication, it is unclear whether this was removed.	Patient to be informed of the error when he returns from day leave, in line with Duty of Candour. All 3 nurses who have used the dosette box to be contacted, and complete a reflection due to assisting a medication error.	Reflection recieved from nurse involved demonstrating learning	No further lessons identified	Closed
GHC76427	19/09/2024	19/09/2024	10:00	Cirencester & Fairfrd Hospital	Ciren Hosp- Coln Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Medication breakages / spoilage	Storage	Oxycodone	No					i was tidying the patients medication controlled drug cupboard when a bottle of discharged patients oxynorm liquid fell and smashed to the floor. a second registered nurse was present at the time	glass removed, cd register updated , remaining controlled drug liquid to be destroyed pharmacist on site so reviewed and also witnessed the controlled drug book and signed that the drug was destroyed	No further action required. All appropriate measures taken	N/A	Closed
GHC76429	19/09/2024	04/09/2024	15:45	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Other (unlisted)	Yes	7500 units		Subcutaneous		patient drug chart for daily fragmin - treatment dose Documented date July but administered in September	No missed dose for fragmin Chart completed incorrectly Photo taken and uploaded to S1	Clerical error on documentation regarding date of administration of fragmin injection. No harm came to patient Staff to ensure they are using the 6 rights of medication administration	Discuss with staff member of this clerical error	Closed
GHC76533	21/09/2024	15/09/2024	06:00	CYPS/PH Community Specialist	CYPS/PH- Children Complex Care	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Other (unlisted)	Yes	As per feed plan		NG/PEG/PEJ		I forgot to sign a medication after administering. I was informed I forgot to sign by another member of staff the following day. The medication was a probiotic		Thank you for completing this datix. Please can you complete the self reflection available in the managing medication errors. Once this has been completed please can you discuss this with your line manager at your next 1-1.	Thank you for reporting this and your honesty in doing so	Closed
GHC76559	21/09/2024	21/09/2024	13:15	ICT	ICT Glos North South DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Cinchocaine + Prednisolone	Yes	1 suppository		Rectal		Visited to administer scheriproct suppository- prednisolone 1.3mg/cinchocaine 1mg. Administration requested daily by GP (given yesterday and today). Noted that medication chart not signed.	Datix. Band 6 for team informed.	Green community chart not signed for the medication - staff member noticed after the administration of the drug. No harm caused to patient. Correct action taken at the time of incident - B6 informed, patient + carers informed, datix submitted and GP informed and new chart requested.	Advised staff members involved to reflect on this incident. 6 R's of medication emailed out to all staff within team as a general reminder to remain safe when administrating medication.	Closed
GHC76586	22/09/2024	22/09/2024	08:55	ICT	Reablement Forest	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Ferrous sulfate	Yes	200mg	200mg	Oral	Oral	Medication given at wrong time, 1 tablet was given this morning which is meant to be taken at teatime.	Patient made aware, I phoned out of hours who advised me to phone 111 when I went back to the patients at lunchtime. 111 phoned just after 12pm and information given, a nurse from 111 phoned me back shortly afterwards.	RA completed all correct procedures, advised patient, apologised to patient, contacted OOH RCO and 111.	Incident down to human error which RA recognised and acted immediately. As a learning point, extra vigilance should be employed when undertaking medication administration, line manager advised. One-off incident, therefore no further training required at this point. However, in case of recurrence, extra supervision/ training would be advised. Discussed with Forest Reablement Lead, incident should be recorded on S1 by OOH RCO. Reablement Service Lead working with OOH team with this.	Closed
GHC76611	22/09/2024	22/09/2024	09:45	ICT	ICT TWNS DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Insulin glargine	Yes	na	44 units	Subcutaneous	Subcutaneous	Patient visit for insulin, driver and peg check. Dialled up 2 units insulin- test shot, dialed up to correct amount, administered insulin into left abdo by pushing needle in until i heard click, once pen pushed down and insulin administered waited 10 seconds before removing needle. Needle casing did not lock and there was some insulin left in bottom of needle casing. Clearly not all insulin administered and needle failed to lock.	Advised patient that she may not have had any or just some of her insulin. She think she felt the needle go in but she finds it painful always as hates needles. Called band 6 to inform of incident. Advised patient to monitor sugars via her libre. To escalate if they go very high. Be mindful of diet. Patient uses PEG for nutrition. Continued to monitor sugars throughout visit. They were coming down. Patient fine in self. Nurses will be going out tomorrow.	Reviewed from notes and discussion with visiting member of staff - Needle was auto shield safety needle in the property - Staff member stated that the needle did click when being held to the skin - Was unsure how much insulin was given so another dose was not given - Patient sensible enough to monitor BGL throughout the day and had a libre on her arm to have continuous monitoring. - BGL the next day was 16.6 mmols patient remained stable. - Spoken with Staff Member and there were no concerns with practice or technique - ?Needle failure - Will be discussed in team time	No further concerns thank you for completing this datix	Closed
GHC76650	23/09/2024	21/09/2024	07:00	Wotton Lawn Hospital	Wotton Lawn- Kingsholm Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Missing medication	Stock balance recording errors / discrepancies	Codeine	No					Staff reported that 2 boxes of Tab Codeine Phosphate 30 mg where delivered on 19.9.24. One was stored on patient box and other on the storage cupboard. Staff returned to work this morning (23.9.24) and this was not found there. Hence escalated to management team due to concerns.	Spoke to pharmacy and confirmed this was delivered on 19.9.24. Checked with other wards just to exclude the possibility of this being misplaced/lented to other ward. Email sent to staff who worked between these time periods to find further information. Staff nurse who did medication round on 20.9.2024 early shift with a supernumerary staff confirmed there were no Codeine 30 mg boxes found on that morning which was later escalated to nurse in charge of shift and confirmed by them. Service user who has the medication prescribed was spoken to and room searched, however the item of concern was not found. Currently awaiting response from other staffs to obtain more information.	* Several searches of clinic and wider ward conducted. * Review of staff members with access to clinic room. * Identified a timeline of events / fact-finding process commenced. * Email message sent to all qualified staff asking for any information they may be aware of regarding location of medication. * Request made to staff for written accounts of their actions (in relation to the missing medications / access to clinic / any observations they have regarding this issue). * Decision making tool implemented in relation to staff statements. * Communication book introduced to clinic for staff to record any information / concerns regarding clinic / medications. * Controlled drug policies printed and circulated to qualified staff, with request to read, understand and to sign to reflect understanding. * Signing sheet with running balance of codeine commenced and checked periodically by ward manager.	* Despite investigations medications have not been located. * Security measures introduced to maintain a close monitoring of this medication. * All staff reminded of their duties as per NMC code of conduct.	Closed
GHC76682	23/09/2024	23/09/2024	15:00	ICT	ICT Chelt Town Centre DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Prescribing	Other (unlisted)	Yes	50ml		Other		Arrived to administer bladder washout. Drug chart did not have a dose filled out.	Phone call to nurse on triage to ask if still ok to give. Rang GP to request new drug chart with dose added to it.	All appropriate actions taken at time of incident.	N/A	Closed
GHC76683	23/09/2024	21/09/2024	03:21	Charlton Lane Hospital	Charlton Lane- Chestnut Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Preparation by administering clinician(s)	Lorazepam	Yes	1 mg		Oral		Patient been given PRN lorazepam which was exceeding 3mgs in 24 hours.	Informed the Duty Doctor. Informed the patient and family.	Member of staff will be asked for reflection and conduct a supervised drug round	NA	Closed
GHC76759	25/09/2024	20/09/2024	15:00	Charlton Lane Hospital	Charlton Lane- Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Disposal	Other (unlisted)	No					Medication was found by Matron in female corridor on top of poster border. Unsure how long this is been there and unable to clarify the medication or the patient this was prescribed for.	Medication disposed off correctly.	Appropriate action taken at time of incident.	No new lessons learnt	Closed
GHC76769	25/09/2024	21/09/2024	18:00	ICT	ICT Glos North South DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Diamorphine	Yes	5mg		Subcutaneous		Visit for stat dose. When checking charts most recent chart full, checked what previous doses patient has been having of diamorphine, flipped over chart to new one and drew up medication diamorphine and midazolam. Administered to patient and re check drug chart after and realised new chart states Morphine no Diamorphine. Spoke with senior who advised to ring ooh gp to re write chart. OOH GP visited.		Thank you for submitting this Datix Having checked the patients notes patient was prescribed Diamorphine for a long period of time - in pump and as stat doses. We were in the period of switching over from diamorphine to morphine with the new medication and doses on the new drug chart. Correct action taken by visiting nurses, who escalated to Band 6 and OOH GP. No harm came to this patient - she had been on long term diamorphine - stat dose given as appropriate.	Handed over to team in team time importance of updated medication charts and checking before administering drug. Human error - new drug chart was not checked correctly before administration of drug. Member of staff aware to always check - 6 Rs to drug administration.	Closed
GHC76781	25/09/2024	25/09/2024	10:00	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Buprenorphine	Yes	10mcg/hr	10mcg/hr	Topical	Topical	Prescription chart dated but not signed for Buprenorphine patch 18/09/2024	Lucy Pearce RN informed, with me at visit	Notes reviewed and staff member identified - line managed informed and they will discuss with them	Good review of documentation	Closed
GHC76836	26/09/2024	26/09/2024	11:00	Sexual Health Service	Sexual Health Integrated ISH	Pharmacy- provider	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Pharmacy	Prednisolone	No					Checked medication received prior to arranging patient collection. Prednisolone quantity error: 105 tablets required for reducing course. Dose reduction directions correct. 3 x 30 and 1 x 15 tablets on labels 3 x 28 original packs and 1 x 14 in "white box" = 7 tablets short No steroid card in bag	Rung Fairview, spoke to Pharmacist who checked it. Arranged return of dispensed items and replacement will be sent on afternoon run including a steroid card. Rung patient to collect in afternoon after delivery due.	Pharmacy provider carried out internal investigation and reminded dispensing team of need for checks and vigilance		Closed
GHC76838	26/09/2024	26/09/2024	09:30	ICT	ICT Glos North South DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Cinchocaine + Prednisolone	Yes	1 suppository		Rectal		visited to administer suppository- administered on 23/09 and 24/09 on MAR chart but pharmacy label incomplete. Then administered on 25/09 on unsigned prescription chart	Datix- attended surgery for signed chart, now in home. Old charts removed.	Pharmacy label reviewed - not enough information on the label to complete a MARS chart. Drug chart in the property not filled out correctly - missing the doctors signature. No harm caused to the patient. Appropriate green community drug chart now in the property.	Staff who had completed and signed the MARS chart, and signed the chart with no doctors signature, have been informed of the incident and will reflect. 6 R's of medication emailed to all staff in NSG team as a reminder.	Closed
GHC76840	26/09/2024	26/09/2024	13:00	Wotton Lawn Hospital	Wotton Lawn- Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Morphine	No					Routine 3-monthly CD balance check. Identified the following discrepancies: - Page 101 Patients Own CD Record Book: 20 capsules of Zomorph 10mg signed in, no record of administration, most recent stock check states 18 capsules. 0 capsules located in CD cupboard. - Page 105 Patients Own CD Record Book: Quantity recorded as 1xpetri dish, 1xbottle and 1xpot, only 1xpetri dish located in CD cupboard. - Page 126 Patients Own CD Record Book: 3 bottles (approx 125mL) of methadone 1mg/1mL recorded, never recorded as administered, 0 located in CD cupboard.	Reported to charge nurse, advised ward manager already aware.	Teaching session ran by Kizzie has been organised for all RMNs.	RMNs unaware of policy and procedure	Closed
										Missing medication	Stock balance recording errors / discrepancies	Methadone	No									
GHC76848	26/09/2024	25/09/2024	10:45	ICT	ICT Stroud Cotswolds DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Drug administration omitted / delayed	Administration	Oxycodone	No					Visited a patient with a colleague for her syringe driver compentency. On arrival and checking medication, realised Oxycodone ampoules had not been collected. I went down to Cainscross pharmacy to collect it, and on conversation with pharmacist it had not yet come through. Rang the surgery and they said that it was on the urgent pile but they could not give a time which it would be ready. I explained that it was urgent and that this ladies syringe driver was due at 11am, but the receptionist said they still could not give a time. The medication had been ordered on the 24/09/24 by the Nurse who had visited, and the shift lead had rang up at 8.30am to make sure it was down as urgent as there was not enough ampoules in the house for the syringe driver.	I rang my shift lead to explain what had happened. Returned to the house and explained to the daughter, and to patient what the situation was. We replenished the syringe driver with the other medication available but had to omit the oxycodone. Shift lead rang the surgery to complain, but practice manager was not available. The surgery rang later to say the medication was ready, so another colleague collected this and took it to the patient's house, and they replenished the syringe driver with the oxycodone in. When this colleague collected the medication, they then only had 3 ampoules available which was enough for that sryinge driver replenishment but left none for further stat doses.	discussion with Practice manager at surgery, difficulty in getting medication script had been time consuming and distressing for the patient. More drugs were requested on the 24/9 but the message was sent by task. it had not been actioned as urgently. After discussion with surgery Manager, DNs given a separate number to ring and advised to request EOL medication by phone and ask for attention of duty Doctor. this will make sure it will be actioned quickly	Communication with GP can be difficult as many people to navigate . Message not always treated as urgent. Now organised to phone in with end of life meds and DNs have a separate number.	Closed
GHC76890	27/09/2024	25/09/2024	10:45	Long Term Conditions	Bone Health Service	Pharmacy- community	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Pharmacy	Denosumab	No					patient arrived for clinic appointment for administration of an injection, he presented with the incorrect medication- wrong dose with different patient name on the item. Reports he had received it from the pharmacy. Patient believes he had already obtained correct medication and the injection had been administered by the community nurses already	Medication not given I contacted his pharmacy, they were unable to confirm if he had received correct injection already, they requested patient return incorrect item to them Contacted community nursing team to confirm information	pharmacy contacted and they requested patient return incorrect item to them Contacted community nursing team to confirm information	Pharmacy to investigate	Closed
GHC76920	27/09/2024	27/09/2024	20:30	Wotton Lawn Hospital	Wotton Lawn- Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Use / possession of over-the-counter (OTC) medicine	Paracetamol	Yes	500mg		Oral		-Patient went AWOL , upon return found one packet of 500 mg paracetamol tablets in that she admitted to take one tablet.	-Handed over to nurses to omitted the dose she has taken whilst she was out. -Updated risk assessment.	leave revoked medical review risk management	patiuent took medication whilst on leave	Closed
GHC76924	28/09/2024	27/09/2024	19:00	Cirencester & Fairfrd Hospital	Ciren Hosp- Windrush Ward	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Controlled stationary (medication related)	None (no harm caused by the incident)	Drug administration omitted / delayed	Monitoring / follow-up of medicine use	Co-beneldopa	No					New admission to the ward from GRH without discharge summary or drug chart.	Contacted hospital ward regarding charts. Staff replied that ambulance crew did not wait for the charts and will send through email. However received discharge summary through email but no drug chart and he is getting timely medications. Contacted them again but the night staff is not sure about drug chart or whether the medications administered at dinner time.	Ward responded appropriately	no lessons applicable to this Trust	Closed
GHC76941	28/09/2024	28/09/2024	09:25	ICT	ICT Stroud SevernHealth DN	GP	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Prescribing	Other (unlisted)	Yes	4 units		Subcutaneous		Visited for insulin administration. Patient prescribed 2 x different insulins. No range on either prescription chart. New Humulin I chart commenced 10 days ago, dose states 1-4 units. No further information. Patient reports she noticed this when the chart arrived, however is adamant that she is prescribed 4 units. Previous plan states 4 units and no other documentation to suggest otherwise.	Discussed with shift lead re appropriate course of action. As patient was able to self administer, and adamant she was due 4 units, for her to self administer Humulin during visit until GP surgery open to complete drug chart. Patient had difficulty doing this but was able to manage safely with minimal support.	Insulin chart re written for Humulin I 4 units and BGL target range documented on insulin drug chart. Copy of new chart added to datix No other action require	Nurse not to except insulin drug chart if not completed correctly. Ensure all DN or HCA are aware to not accept drug chart if not written correctly with all areas completed and clear.	Closed
GHC76997	29/09/2024	28/09/2024	15:00	Intravenous Therapy Team	IV Therapy Services	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Ordering, collection or delivery	Ertapenem	Yes	1g		Intravenous		Patient discharged from ward 9B GRH with no IV Ertapenem despite ward being asked to provide.	Nurse had 1 dose in bag of consumables, ward 9B contacted to advise no drugs sent home.	Failed discharge from GHT. IVTT have stock of IV antibiotic so patient did not miss a dose.	Ward contacted and informed that drugs were not send home with the patient.	Closed
GHC77037	30/09/2024	27/09/2024	16:00	ICT	ICT Chelt Peripheral DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Levomepromazine	Yes	25mg	25mg	Subcutaneous	Subcutaneous	Visited patient on 27/09 to assess for stat dose - was settled during visit therefore stat dose not clinically indicated. Checked drug chart and found that stat dose of levomepromazine 25mg administered at 12:50pm by H@H nurse. Additional stat dose of levomepromazine 25mg administered again at 15:15pm. However, drug chart states levomepromazine is to be administered 6 hourly.	Apologised to family and informed them of stat dose being administered before next due. Spoke with DN who visited to make aware of drug error. Escalated to manager on duty. Completed a datix.	22/10/24 All appropriate actions completed & apology at time to family. Medication ensured patient had a comfortable evening and no harm. Nurse responsible human error due to pressures at present but has reflected and had support from CNL as felt dreadful with the incident	22/10/24 No harm and nurse to ensure she has realistic amount of visits in her shift to avoid errors in future	Closed
GHC77043	30/09/2024	30/09/2024	13:00	ICT	ICT Chelt Peripheral DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Citric acid	Yes	x2 30mls		Other		Patient has twice a week bladder washouts, drug chart in the house states SubyG 3.23% citric acid - On patients notes, nurses have been documenting 6% citric acid but signing for 3.23%.	Photos taken of drug chart to upload to datex.	At time of incident Nurse checked the drug chart and documentation in notes. On investigation. GP had previously prescribed Uro-tainer 6% as well as 3.23% citric acid 600mls Uro tainer Suby G 3.23% normally comes as 2 chambers 30mls each chamber. Will ask nurse visiting next to check what is written on the drug chart.	Photo of drug chart not attached to datix or patient's notes. Will ask nurse to upload if still has photo and reiterate the importance of uploading photo at appropriate time. Discuss with team the importance of checking the drug chart and writing the correct documentation in patient's notes.	Closed
GHC77086	01/10/2024	01/10/2024	11:20	ICT	ICT Cotswold North DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug has expired	Administration	Hydroxocobalamin	Yes	1mg/1ml		Intramuscular		i gave a injection of hydroxocobalamin 1mg/1ml not realising it had expired the previous day.	apologies verbal immediately given to patient and reassurance patient clincal observation taken and checked within normal limits nurse in charge of shift informed.	Nurse identified B12 medication given out of date by 1 day. Apologised to the patient. No harm caused to patient. Appointment booked for 3 months time.	Staff to be vigilant with exp dates on medication prior to administration.	Closed

GHC77118	02/10/2024	19/09/2024	15:35	CYPS/PH Public Health Nursing	CYPS/PH- Immunisation Team	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Medication storage issue	Storage	Other (unlisted)	No					Cold chain breach during transportation of Live nasal flu vaccines. Temperature on leaving school 7.7. 7 and on return to base 9.9.9. Thermometer on return to base reading 9.9.9 vaccine temperatures within cold chain range throughout session vaccines on return to base	Vaccines felt cold on return to base however Due to live nature of vaccines, 100 nasal fluenz vaccines disposed of in line with cold chain policy. Thermometer removed from circulation Incident reported on Immform 2.10.2024 and to ICARS on 2.10.24 Incident discussed with Commissioners on monthly call 2.10.24	Issue with thermometer Thermometer removed from circulation Incident reported on Immform 2.10.2024 and to ICARS on 2.10.24 Incident discussed with Commissioners on monthly call 2.10.24	Thermometer removed from circulation and all others checked for accuracy.	Closed
GHC77123	02/10/2024	02/10/2024	09:30	ICT	ICT Glos North South DN	Pharmacy- provider	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Medication storage issue	Pharmacy	Other (unlisted)	No					Arrived at patient home for bgl and insulin Patient very distressed due to pills dropping on the floor Due to Dossett box small compartments not being sealed and pills loose inside Dossett box 3 out of the 4 Dossett boxes loose pills	Picked all loose pills up of the floor Rang chemist to inform of this Give patient the correct filled sealed Dossett Arranged to have Dossett picked up and redone	Correct action taken at the time of incidence. No harm caused. For pharmacy to review their dosette boxes and ensure security before delivering to patients.	For pharmacy to review their dosette boxes and ensure security before delivering to patients.	Closed
GHC77125	02/10/2024	01/10/2024	11:30	ICT	ICT Stroud Cotswolds DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Fentanyl	Yes	100mcg/ hr		Topical		1 x Fentanyl patch missing	Reported to team	Review of the patches, there were 2 boxes both opened as stock had been counted. 1 box has 5 patches in and 1 box had 1 patch in. nurse replaced the patch from the full box, and threw away the box with the 1 patch still in it.	Stock checks need to be more careful staff rushing and chatting to patient so easy to be distracted. Advise don't open new boxes to count the patches as if sealed they should be correct and Nothing in the box to be broken.	Closed
GHC77134	02/10/2024	02/10/2024	10:45	ICT	ICT Cotswold South 2 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Controlled stationary (medication related)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Buprenorphine	No					Routine visit. Record of stock medication for Butec patches form completed and two were missing. HCA did stock check last week and documented prescription chart	Stock check repeated unable to locate missing patches. Photo taken of drug chart and stock sheet. Informed patient. Informed shift lead nurse. Lock box to be collected.	Potential clerical error from previous community nurse when completing stock check Plan for locked box to be provided to ensure all patches are kept in safe place. Checked with Care Agency to ensure they had not applied patches to the patient.	To document on S1 of stock level in property Staff to ensure they check the amount is correct and documented.	Closed
GHC77162	03/10/2024	03/10/2024	08:50	ICT	Reablement TNS	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Oxycodone	No					Thursday morning dossette was already opened and no medication in compartment. Patient said she hadn't taken medication. On review of the MARs sheets, it would appear previous evenings medications may have also been taken at some point as the MARs sheet documents medication declined at time of RA visit.	RA telephoned Duty RCO and patients doctors surgery for advice. RA spoke to pharmacist at surgery and detailed what medication was within each compartment of dosette. pharmacist telephoned RA back having spoken to GP. Pharmacist advised no concern. Photo taken of dosette and MARs sheet and emailed to duty RCO, SRA, DN. Documented occurrence in Reablement folder under medication progress notes. RALead confirmed she had spoken to pharmacist at Dr surgery.	appropriate datix thank you reablement lead liaised with GP and pharmacist same day as notification and medications were discontinued due to risk patient was seen face to face by reablement lead and DN the following day patient was then discharged and safetynetted with ongoing referral to frailty nurse specialist for GP surgery GP also made contact with son	incident noted, datix completed and appropriate actions taken in a timely manor patient harm avoided please take this datix forward to your team to promote learning and effectiveness of datix completion	Closed
										Wrong time / frequency	Administration	Irbesartan	No									
										Wrong time / frequency	Administration	Gliclazide	No									
GHC77166	03/10/2024	03/10/2024	08:30	ICT	ICT Glos Asp & Stbridge DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong time / frequency	Administration	Glucose	Yes	10mg in two days	5mg 1x weekly	Subcutaneous		First time meeting patient today. Joint visit with newly qualified community nurse for competencies. Visit to administer insulin. Advised by patient she was due to have her Mounjaro 5mg today. Gave Newly qualified nurse the medication and chart along with the insulin chart for her to carry out procedures. She carried out injection and completed chart. However on looking into patient record on S1 noted that it was due for Wednesday and had been given yesterday. Asked patient if this was the case and noted on system one had entry for yesterdays injection, care plan was complete therefore error occurred today with extra dose. Upon return visit noticed that this had been documented yesterday.	Apologised to the patient. Contacted the GP for advice. Informed senior community nurse. Phone call with patient to check well-being. Return visit to check BGL as directed by GP. Safety netted patient for the rest of the day. Long discussion with NQN where both of our failings were from this error. We will both complete reflections to ensure this does not happen again. 4.10.24 -Incident updated to remove staff names.	Patient safety netted with the GP and did not suffer obvious harm. Both members of staff have completed a refection and completed their medicines management and Insulin training. They have both reflected with our Clinical Facilitator and they are both deemed fit to resume insulin visits.	Not to rush.	Closed
GHC77169	03/10/2024	03/10/2024	11:00	The Vale Hospital	Vale Hosp- Peak View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong patient	Administration	COVID-19 vaccine	Yes	0.5ml		Intramuscular		Alerted by the staff on the ward that patient who was NOT scheduled to receive a flu and COVID vaccine today had a vaccination card on her table with another patient's name on it. Patient who was expecting to have the vaccines said that she had not been vaccinated. Her medication chart had been updated to say that this had been administered.	Informed doctor. Apologised to patients. Informed vaccination team coordinator. Will need to inform patients family as she was not scheduled to receive the vaccine as she is unable to consent. 07/10/24 Clinical Lead for Nursing, Therapies and Therapies. Discussed incident with staff involved who has completed a written reflection. Summary of incident details and learning emailed to incident reporter 03/10/24. Copy of email filed in progress notes.	Correct process for checking patients identification did not take place. Patients are all in side rooms, with wrist bands and ID in the room. Lead for the vaccination team has communicated to their team about importance of correct ID for all patients. Check completed of all patients to ensure ID wrist bands are in place	Lead for the vaccination team has communicated to their team about importance of correct ID for all patients.	Closed
										Wrong patient	Administration	Influenza vaccine	Yes	0.5		Intramuscular						
GHC77213	04/10/2024	04/10/2024	09:45	ICT	ICT Chelt Peripheral DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong / unclear dose or strength	Administration	Insulin glargine	Yes	14 units		Intramuscular		- Insulin dose prescribed;- (on 13/08/2024) Semglee 14 units. - Nursing staff have been administering;- Semglee 10 units - Care plan states semglee dose is 10 units. - Patients BGL within target range. Previous BGL has been above target range.	- Gave dose as prescribed. - Contacted lead nurse and requested for care plan to be changed. - Photo taken of front of insulin chart.	see datix progress report	see datix progress report	Closed
GHC77239	04/10/2024	03/10/2024	10:00	ICT	ICT Cotswold South 2 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Drug administration omitted / delayed	Administration	Dalteparin	No					Phone call received stating that surgery did not want the patients INR checked yesterday and to just check today (4/10). I checked this with the surgery as I was aware patient should be having Fragmin daily and INR results had been out of range but they confirmed not needed. Subsequently I deleted the visit and therefore pt did not receive fragmin dose	Today I have checked the patients observations, apologised to the patient and informed the GP of the missed dose	GP was informed of missed dose No harm to patient, duty of candour applied.	teaching to be fed back about checking info on visits to avoid errors such as this	Closed
GHC77249	04/10/2024	03/10/2024	22:00	The Vale Hospital	Vale Hosp- Peak View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Prescribing	Atorvastatin	Yes	03/10/2024	10mg	Oral	Oral	Ward sister informed by ward pharmacist that patient prescribed 10mg of atorvastatin at 22.00 on paper drug chart from acute trust, and also on discharge summary. Patient prescribed 40mg of atorvastatin at the Vale by ward GP. Not documented as to why increased.	Ward sister rang ward doctor to confirm if dose increase was intentional or a mistake. Ward doctor confirmed it was a mistake. Apology given to patient verbally and informed him that no harm would have occurred to him and this was confirmed by ward GP and by pharmacist. Patient accepted apology. Dose to be amended by ward GP tomorrow on saturday. There is a note written by pharmacist for tonight for nurse to not give 40mg and to give 10mg instead. If night nurse is not satisfied to give the 10mg as per instruction from pharmacist, then to omit the dose tonight. Patient is aware he may miss a dose of atorvastatin tonight.	Incident reviewed and believed to be a prescribing error by the admitting ward doctor. Staff did not check the systmone medication chart against the paper chart to see if they matched up and staff have been informed that this would be a beneficial action when administering medication to a new patient. Explanation and apology given to patient on behalf of doctor.	Doctor to be more mindful of what is being prescribed. Nurses to check paper drug chart against newly prescribed system one chart to ensure that no errors have been made. This is not routine practice on the ward, but could be encouraged as good from this medication error.	Closed
GHC77268	05/10/2024	05/10/2024	08:10	Stroud Hospital	Stroud Hosp- Jubilee Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Lidocaine	Yes	2 patches	1 patch	Topical	Topical	when completing a medication round patient informed me that she had 2 lidocaine patches on. The patient was only prescribed 1 patch per day.	patches taken off and nurse in change informed, who verbally handed over to the doctor. Patient apologised to.	Incident identified and handed over to appropriate staff in a timely manner. Patient also informed. Please see emails attached for further information. Patient discharged from our service not long after and no harm caused.	- To ensure any verbal handover to further medical practitioners is also documented to show clear communication between staff - Nurses advised of the importance of adherence to medication prescriptions, as well as ensuring the use of transdermal patch charts/care plans. Safety brief updated to also state this. - Discussion held with staff involved	Closed
GHC77288	06/10/2024	06/10/2024	09:00	The Vale Hospital	Vale Hosp- Peak View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Ordering, collection or delivery	Liquid paraffin	No					Patient is nil by mouth. On PEG feed regime 1250mls a day - Nutrison Protein Advanced. Was informed when I came on duty this morning, that there is no Nutrison Protein Advanced left on the ward. So once patient has his 9am feed of 250mls this morning, there will be none left for lunch time bolus feed or overnight feed which starts at 8pm. There will be no feed for tomorrow morning 9am bolus feed. Last order on system one 26/09/24 not clear if ordered by anyone else since. To check with pharmacy tomorrow in opening hours. No ward GP today. I will order the feed today.	Ward Sister on duty last night rang round some community hospital and acute wards. Ward Sister on duty this morning also rang round other acute wards and local community wards. Ward sister then rang emergency on call pharmacy to delivery supply to ward as urgent today. Waiting at present to see if order can be fulfilled. Ward sister tried in the interim to locate emergency feeding policy for trust should order not be fulfilled. Unable to locate- access denied. Ward sister rang band 7 on call who also could not locate emergency feeding regime, and band 8 now looking into this. - Plan: in the interim if order cannot be fulfilled today, then GP on Windrush ward Cirencester will review and remotely prescribe Fortisip Protein plus boluses to be given.	Ward are checking stocks of feed earlier on in the week to identify any potential issues. Communication with pharmacy is also key to managing this and staff are to be encouraged to regularly check with pharmacy progress of any order.	As there is an issue around supply issues of some feed there is being some work being completed involving the dietitian to produce an emergency feed regime for patients should their feed become unexpectedly unavailable.	Closed
GHC77296	06/10/2024	06/10/2024	13:00	ICT	ICT Chelt Peripheral DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Insulin glargine	Yes	Unsure - documented 12 units	16 units	Subcutaneous	Subcutaneous	Went to document patients insulin on systemone and noted that since 30th September 12 units of semglee has been documented. Patient is on 16 units of semglee.	Went back to the property to double check drug chart and took photo of drug chart to upload.	Reporter returned to check the drug chart. Photo uploaded to datix of the drug chart. Emailed nurses involved in drug documentation error to reflect on their error. Advised to ensure they check their documentation in future.	Support to be given in Team Time re ensuring correct documentation is written. Ensure 'cut and paste' if used is correct	Closed
GHC77306	06/10/2024	06/10/2024	14:00	ICT	ICT Glos HQR DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug has expired	Administration	Insulin glargine	Yes	24 units	yes	Subcutaneous	Subcutaneous	When visiting to administer Insulin found that insulin being used had passed its expiry date. according to drug chart this pen had been used on three occasions	Telephoned and reported to SCN expired date pen and drug chart photographed and emailed to SCN. Expired pens discarded and new in date pen started today.	Notes read and unfortunately the patient received 4 x doses of out of date insulin. The patient has poor memory and it had been established that she was not managing or administering her insulin as prescribed. This likely contributed in her being able to accumulate out of date insulin. Time has been booked to speak to each individual involved. The individuals involved will be asked to complete the six steps to insulin safety again. The individuals involved will be asked to complete a reflective piece of work. The individuals will be required to refresh and complete their medicines management again to reduce risk of reoccurrence.	Essential to role that medications are checked prior to administering to ensure that they are in date. Email to team and discussion within team time about the importance of the 5 R's of safe administration. Reiterated the importance of weekly stock checks , this is to include checking dates. Patient was being seen by DN's for leg care during the period where she was not managing her insulin, so her BGL potentially should have been discussed previously and could have been raised before as this could have been contributory to poor wound healing.	Closed
GHC77309	07/10/2024	06/10/2024	21:39	Wotton Lawn Hospital	Wotton Lawn- Dean Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Lorazepam	Yes	2 mg		Oral		Patient self reported that the Late shift medication nurse gave her 4mg lorazepam (PRN) as against prescribed 2mg. Patient further reported the same nurse gave her 75mg Promethazine (PRN) as against 50mg prescribed. According to the patient, these medications were given to her along with her Nocte medication just before the medication nurse finish her shift. Patient admitted she knew these were wrong doses before taken the medication but still went on to take them. When asked why she did not query the administration of these medication knowing fully well they were wrong doses, Patient said she did not want the Nurse to feel bad and that she wanted more medication to help her sleep.	Patient declined to have her physical observations taken. Duty doctor was informed. Duty doctor advised that administration of Lorazepam and promethazine should be suspended for 24 hours since patient has had the recommended maximum doses in 24 hours as per BNF. This means the next administration should be at 21:39 hour on the 07/10/24. This information has been communicated to the patient	Prescription chart reviewed Information obtained from staff involved No evidence of a drug error	With all information obtained, I am satisfied there was no error	Closed
										Wrong / unclear dose or strength	Administration	Promethazine hydrochloride	Yes	2mg		Oral						
GHC77341	07/10/2024	07/10/2024	16:00	MIIUs	MIIU- Stroud Hosp	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Adverse / allergic drug reaction (when used as intended)	Administration	Co-amoxiclav	No	1 tablet 500/125mg		Oral	Oral	patient came in due to cat bite to arm, pt given antibiotics, patient was given co-amoxiclav, pt was sent home, patients notes written after assessment, on checking patients allergy on medication list in system one, it states she is allergic to penicillin v, phoned patient to ask if she is allergic to penicillin and she said yes, she states it was a long time ago and she is unable to recall what reaction she has, pt was advised to come back to change antibiotic, pt stated that she has taken one tablet one hour ago without looking at the box, no itch or swelling noted, feels well in herself	pt has no reaction to the antibiotic one hour after taking it advised to take antihistamines for any rashes or pruritus	Notes reviewed	EP reminded to check patient's records for allergies and not to reliant on what patient says	Closed
GHC77358	08/10/2024	03/10/2024	15:00	ICT	ICT Cotswold South 2 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Information / advice to patient not given / wrong	Information / advice to patients	Cyclizine	Yes	correct prn dose		Oral		Ex-wife wanted me to look at medication charts as she says pain and nausea medication had been changed to twice daily, however I was unable to see this in clinic notes on S1. Noticed that ex-wife had changed Reablement medication records and drawn a line through the metoclopramide and added the cyclizine instead. She had signed this. This makes the chart unclear as to which has been administered.	Informed ex-wife she must not adjust charts as this may cause a medication error. She should speak with team administering meds instead. Advised the Reablement co-ordinator and she will arrange for the chart to be reviewed. Unable to take photo as phone on charge in car - battery too low for pictures	Clearly documented and well escalated within MDT Conversations had with wife about altering charts	Could utilise lock boxes more freely to reduce risk of charts being tampered with To ensure equipment - laptops and phones adequately charged prior to shift	Closed
GHC77380	08/10/2024	08/09/2024	10:10	Medicines Management	Medicines Management	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Ordering, collection or delivery	Midazolam	No					A box of 10 Midazolam 10mg/2ml injections was transferred from Coln ward to Windrush ward.	The box was unused and returned to Coln ward on 03/10/2024 by pharmacists.	SOP discused again at team update 11th ocotber for staff to follow in future	staff did the best the could at the time to save the other ward having to keep coming up and down to collect a vial of the drug, staff now aware of the SOP	Closed
GHC77390	08/10/2024	19/09/2024	14:30	ICT	ICT Cotswold South 2 DN	Pharmacy- community	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong formulation	Pharmacy	Other (unlisted)	Yes	one application		Other	Other	Visited patient to carry out dressing change. Patient is in reduced compression and bandaging removed did not have the R on them that reduced should have. Redressed leg and used compression in house, then realised this was not reduced either - returned within 30 mins and changed to standard bandaging. Labels on boxes from pharmacy state reduced, but labels are on full compression boxes (40mmHg).	Explained to patient why we couldn't use the compression in house and why I was removing the compression until the correct one is obtained. All remaining boxes of compression kits returned to local pharmacy with patients consent and pharmacy have been asked to supply correct kits and to deliver to patient. Patient happy with plan, thanked me for being so observant	Reviewed notes - no harm to patient Pharmacy had labelled box incorrectly- contributing to the error Both staff members that had visited the patient informed of error	Staff members informed of error - advised to check label and box in future Pharmacy informed of mistake by visiting nurse No further action required	Closed
GHC77469	10/10/2024	09/10/2024	09:40	Crisis Resolution Home Treatmt	CRHT West Glos	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Insulin human	No					Ward requested support from Crisis to team to facilitate safe administration of medication for patients overnight leave. Medication chart stipulates units to be given as 24units. Patient confirmed that he had 26units.	Rung Crisis to confirm that insulin dose given was 26 units as per rio entry. Staff member confirmed that they administered or supported patient with 26 units contrary to the medication chart. Medic informed of medication error.	Met with staff member to discuss what occurred and completed reflection. Further clarification on referral from wards as we do not use the prescription section of Rio.	Gaining accurate medication at point of referral when taking referrals from wards.	Closed
GHC77476	10/10/2024	08/10/2024	14:00	NTQ management	Outreach Vaccination Team	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Contra-indication in relation to drugs or conditions	Administration	COVID-19 vaccine	Yes	0.5ml		Intramuscular		In my role as a peer vaccinator I mistakenly administered Spikevax JN-1 (COVID vaccinations) to two members of staff who were 17 years of age. Whilst the vaccine can be delivered to under 18's, I am not covered to administer this to under 18 year olds under the current PGD. This medication error was not picked up until data was entered onto NIVS system. Patients both consented to vaccination and had previously had full course of COVID immunisations.	Checked with Lead pharmacist re implications - medication is licenced for under 18's but not covered by our current PGD. Manager of the two students has been made aware, I will contact them both to apologise and explain situation. Clinical Lead for NTQ Projects will report ICARS form. I have completed a written reflection on this medication error, and discussed with my line manager. Whilst it was easy to assume that these young men were over 18, as they were at work and consented to the vaccination, I should have followed the NMC code of conduct, and the PGD and checked their dates of birth and realised they were not 18. I will remember to always check in future, and not assume age. 11/10/24 Clinical Lead NTQ Projects - ICARS form submitted. 16/10/24 Clinical Lead NTQ Projects. Copy of email response to ICARS queries saved in progress notes.	Vaccination staff reminded administering Spikevax JN.1 although licenced for over 12 years vaccination of under 18s is not covered by the current PGD & NP. Staff to check DoBs for any people coming forward for a Spikevax JN.1 vaccination that they are over 18 years. Clinical Lead for NTQ Projects has requested for the ICB to allocate GHC some Comirnaty JN.1 stock so we can offer under 18 staff and patients a Covid vaccine. Staff to be familiar of SOP for offering more than 1 type of vaccine at a vaccination session.	As above	Closed
GHC77488	10/10/2024	09/10/2024	15:30	Sexual Health Service	Sexual Health Preg Adv PAS	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Ordering, collection or delivery	Mifepristone	No					10/10/24 10:00 Noted that Fairview Pharmacy delivery of Mifepristone had been stored in fridge in lab at Hope House. The controlled drug order book was left on the bench above the fridge	Removed the Mifepristone from the fridge, highlighted to member of staff who received the delivery, quarantined in medication cupboard in the HIV office (treated as a controlled drug in sexual Health), unable to phone manufacturer to obtain stability data as no valid phone number so emailed the query through. Highlighted to my line manager.	Spoken with reception and HCA staff members following the incident. Identified as human error in chain of events due to limited staff availability and having to multitask. Confirmed with manufacturer the stock was not compromised and could be unquarantined for patient use. Spoken with Fairview re drivers having to wait or not leave stock if appropriate staff not available at time of delivery.	Medication receipt discussion with relevant staff completed	Closed
GHC77494	10/10/2024	10/10/2024	15:21	ICT	ICT Chelt Peripheral DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Information / advice to patient not given / wrong	Information / advice to patients	Citric acid	Yes	60ml	60ml	Other	Other	Bladder washout administered but washout was prescribed for another patient. Dose was correct and solution was in date. Sticker on outer packaging for another patient.	Checked dose and date prior to administering washout. Didn't check sticker on outer packaging and threw it away, wife made me aware. Datix coompleted. No harm was caused.	SU had been on respite in a care home. The bladder washout was from another resident in the care home that had been sent home with SU. Care home contacted and informed of the error in sending home other residents medication. I spoke to one of the nurses who will pass on my concerns to the care home manager.	Ensure when administering medication the following guidelines are adhered to Right Patient Right Medication Right Dose Right Route Right Time to discuss with nurse who completed the datix	Closed
GHC77503	10/10/2024	01/10/2024	19:00	Medical	Medical Profession Leadership	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Prescribing	Mycophenolate mofetil	No					Patient was admitted in the late afternoon to priory ward, duty doctor was handed over a list of meds to prescribe but not all meds were actioned. Critical med (antirejection meds post kidney transplant) were not prescribed and therefore subsequent doses were missed. Error was picked up during pharmacy medicines reconciliation the following morning.	Pharmacist contacted ward team, ANP prescribed medications and organised for ward staff to collect from pharmacy ASAP to prevent further missed doses.	I made contact with the doctor that did the prescribing. The doctor confirms that she had prescribed all the medication that was given to her by the patients husband and no further details were available on JUYI.	All attempts should be made to ensure patients are prescribed all the medication they are on. This should include psychotropic medication and medication for physical health. If there are any doubts then consideration should be given to speaking with a pharmacist for clarity.	Closed
										Missing medication	Prescribing	Tacrolimus	No									
GHC77519	11/10/2024	10/10/2024	22:30	ICT	ICT Cotswold North DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Prescribing	Midazolam	Yes	5mg	5mg	Subcutaneous	Subcutaneous	Attended palliative patient symptom relief - drug chart not dated for stat doses. Syringe driver not dated had been set up and stat dose given earlier on in the day. Patient agitated, in pain and has secretions.	Rang OOH GP - advised for verbal order due to urgency of symptom relief. OOH GP discussed doses to be given. OOH GP read GP notes could see that syringe driver prescribed and details on RIO. Will email across verbal order advised to call again if needed will make day team aware to get chart dated.	Staff member involved aware of error and reflection completed with colleague Chart taken to Gp surgery and dates added the day after the incident was reported Reminder cascaded to North Cots Community Nursing Team via Team Time on the same day and circulated with minutes of meeting Email reminder sent today to all GP surgeries in North Cots PCN asking for Gp to check they have included a start date when issuing administration charts for JIC meds and request that this is discussed at Gold Standards Framework meetings as reminder to all	Check start date is present on Just In Case administration chart when stock count for Just in Case meds is undertaken and when a new administration chart is issued	Closed
GHC77556	11/10/2024	25/09/2024	17:30	Sexual Health Service	Sexual Health Integrated ISH	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Supply issue	Ordering, collection or delivery	Co-trimoxazole	Yes	1920mg tds	1920mg tds	Oral	Oral	Incident identified by Pharmacist following Patient's clinic appt that he had not received the full course of his antibiotic treatment.	Pharmacist discussed with consultant the following day, and treatment course was re started.			Being Reviewed
GHC77622	13/10/2024	09/10/2024	08:05	ICT	ICT Stroud Cotswolds DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Drug chart errors - not signed, recording, other	Administration	Insulin isophane human	Yes	4 units	8 units	Subcutaneous		Visit for blood glucose monitoring and insulin administration, new insulin charts in property that were started on 8/10. Insulin administered as per community written insulin charts - 38 units lantus and 4 units of Humulin I. On reviewing/writing notes on system1, noted that this was not the requested dosage from diabetic nurse. BGL's remained consistent and no evidence of low BGL.	Contacted B6 in referral for advice. Contacted diabetic nurse for advice who advised to get new charts written up at 28 units of lantus and 8 units of Humulin I - which is what she originally requested from GP surgery, and to start tomorrow. Apologised to patient for the mix up and that new charts will be completed to commence tomorrow. Explained to care home staff what had happened and they have an MDT meeting today with the surgery and will discuss then. Phoned GP surgery to highlight the issue to a GP and to ensure new insulin charts are written up on MDT meeting ready for the following day. Advised home to monitor for signs of Hypo.	GP made a mistake and it was recognised after the insulin administration. Nurse attending contacted all the right people and successfully got the doses changed ready for the next visit. no ill effects felt by the patient but she was in a place of saftey and could be monitored regularly over the next 12 hours.	GP made a mistake and it was recognised after the insulin administration. Nurse attending contacted all the right people and successfully got the doses changed ready for the next visit. no ill effects felt by the patient but she was in a place of safety and could be monitored regularly over the next 12 hours.	Closed
										Drug chart errors - not signed, recording, other	Administration	Insulin glargine	Yes	38 units	28 units	Subcutaneous						
GHC77658	14/10/2024	11/10/2024	09:36	Charlton Lane Hospital	Charlton Lane- Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug has expired	Preparation by administering clinician(s)	Levothyroxine	Yes	100 MICROgrams	unsure how many times expired meds were given	Oral		Student Nurse was preparing and administrating medication under the supervision of a qualified nurse. The patient is prescribed Levothyroxine 125 MICROgram. The medication came in 100mcg and 25mcg. When checking date of the 100mcg Levothyroxine, the medication was dated 08/2024 (2 months out of date). It would appear that this medication has been given previously despite being out of date.	Student Nurse showed Qualified Nurse and informed them of the out of date medication. The out of date medication was discarded. Another 100mcg packet was sought from the cupboard.	Medication removed from the meds trolley and kept safe for pharmacists to look into	Staff to ensure they are undertaken Popam safety	Closed
GHC77667	14/10/2024	11/10/2024	13:00	ICT	ICT Forest North DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Levomepromazine	No					Visiting patient for routine syringe driver replenishment. Whilst performing stock check of all medication, noticed that Levomepromazine 25mg/1ml had been counted in as 10 ampules present by 2 previous visiting colleagues, but only 5 ampules in property. Checked dispensary notes and only 5 ampules had been prescribed and dispensed for this patient and therefore all medication accounted for and no missing medication. Wrong total of medication had been stock checked in.	- Informed senior colleague - Checked S1 documentation and dispensary - Checked GP prescription of medication - Accounted for mistake on stock sheet - Datix completed	correct actions taken by reporter - prescription checked and stock balance correct - discussion at team time regarding opening boxes and counting medications	- no further actions required all medications accounted for	Closed
GHC77670	14/10/2024	14/10/2024	14:00	Sexual Health Service	Sexual Health Preg Adv PAS	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Prescribing	Ethinylestradiol + Norelgestromin	Yes	3 patches given to apply to skin 1 patch for 7 days, then new patch for another 7 days		Topical		Patient attended to collect EVRA contraceptive patches, given x3 patches only as this is what had come from Fairview, described how to use ie one patch for 7 days then apply a new patch. The discharge letter had stated 3/12 supply of patches. As patient was a new user of the patch I thought fair to give only one month supply as she lives in GL1 area. Patient left building.	On returning to desk and Lilie patient system, noticed the Dr had prescribed for 3/12 supply of patches. Spoke to pharmacy service colleague and they advised to phone medication provider to question what was written on the order. The advised 3 months supply requested, however had only stipulated quantity as x3 patches (which for 3 months should have stated x9 patches, which is content in one box). Spoke to our lead pharmacist and she noticed error in prescribing on Lilie system. I phoned patient and explained to use as I had described and apologised and she can call to let us know when she can call in for remainder order.	Confirmed correct direction on original dispensing label, with 3/12 supplied in total after communication at time issue identified.	Spoken with prescriber since error originally identified. Was correct quantity requested, but incorrect directions on Lilie.	Closed
GHC77673	14/10/2024	14/10/2024	08:45	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong / unclear dose or strength	Stock balance recording errors / discrepancies	Insulin human	Yes	6 UNITS		Subcutaneous		Patient is on daily insulin, two different types. Dose of HUMULIN I was increased from 4 units to 6 units on friday 11 october and new drug chart generated. System one records indicate that the previous dose of 4 units had been administered on 12th and 13th october, and the care plan in clinical tree still instructed 4 units. At visit, paperwork checked, new drug chart in place and had been completed by staff on 12th and 13th, written that 6 units were administered. Appears to be incorrect recording by staff visiting on 12 and 13 october on system one .	Confirmed from communication and previous review of records that the correct dose was 6 units, medication administered correctly and drug charts completed correctly during visit. Photograph of drug chart taken for datix. datix completed for learning from incident. Care plan stopped for 4 units and new care plan created with correct dose of 6 units.	Incorrect dosing of insulin given to patient of 2 units for 2 days. Patient had high level of Blood glucose levels (BGL) on 12th October. Encouraged to drink fluids to reduce BGL down 13th October BGL remained high - patient had been drinking alcohol which may have caused BGL to remain high. Appropriate guidance and advice given to patient regarding management of high BGLs.	Incorrect reporting of harm - changed from no harm to low harm as incorrect dose given to patient. Staff to be reminded to check drug chart - 6 steps of insulin prior to administering medication. Share incident at Team Time	Closed

GHC77683	14/10/2024	14/10/2024	17:00	ICT	ICT Forest North DN	GP	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Prescribing	Midazolam	No					- Referral to DNs for stat dose for patient - patient not known to DNS - JIC medication not in property - no one who can collect medication for patient so GP asking DNs to collect medication as patient agitated - Attended pharmacy that GP had said medications had been sent to, medications not there and had been sent to a different pharmacy - Attended second pharmacy - pharmacy unable to dispense medications as no green slip for 2 of the medications and wouldn't dispense the other 2 as they all needed to be dispensed together - white slip issued by pharmacy for half of the medications, taken to another pharmacy and medications collected. - Attended patients property - EOL drug chart in property but not signed. - - Patient unwell NEWS 12 (sats 70)confused and wandering - discussion with NOK - did not want hospital admission - NOK had been told by the GP last week that bloods would be taken to rule	- Urgent request made to OOHs GP for review tonight - explained that I had concerns regarding midazolam being administered as patient wandering and confused, high risk of falls. - OOHs GP asked if I would take a verbal request - advised i feel patient needs a face to face review. - Message sent to GP surgery to request outstanding JIC medications are delivered to property and to confirm if blood test needed	21/10/24 CNL review. Datix content shared with practice manager to investigate and take the learning forward.	Thank yo for your datix. Learning to be identified by GP practice.	Closed
GHC77687	15/10/2024	14/10/2024	21:15	District Nursing (ENDS)	ENDNS- Out of Hours DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Levomepromazine	Yes	6.25mg		Subcutaneous		JIC medication signed for on chart in property without valid prescription- not dated or signed. Noted x2 charts in place- incorrect chart signed	Shift lead informed of error- no acute action taken as the medication administered was in line with the prescribed ranges/timings/route however no signed on the correct chart for multiple medication. Made day staff aware of visit	Discussion had with Team re importance of checking charts re medication	Staff to always ensure charts are written correctly at each visit	Closed
										Drug chart errors - not signed, recording, other	Administration	Glycopyrronium bromide	Yes	200mcg		Subcutaneous						
GHC77706	15/10/2024	09/10/2024	13:00	Recovery	Recovery Stroud	Pharmacy- provider	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Ordering, collection or delivery	Clozapine	No					2 Patients given wrong medication (Clozapine)	Both patient contacted staff that they have wrong medication - checked and confirmed that none of the medication was swallowed b patients - all meds in chemypack intact. Pharmacy contacted and she has apologised for the error caused.	Discussed with pharmacy technician who was running clozapine clinic last week. She states that PRN medication bags were attached to incorrect sets of dosette boxes. Reflects that she should check all medicines that are given out to patients and not make assumptions when supplies are bundled up. Reflective account completed. Will be brought at next pharmacy clozapine clinic meeting and next dispensary meeting.	as above	Closed
GHC77728	15/10/2024	13/10/2024	01:00	Charlton Lane Hospital	Charlton Lane- Chestnut Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Lorazepam	Yes	0.5 MGS		Oral		Patient been administered Lorazepam 0.5mgs at 1:00 hrs, when it was px Max 3 mg per 24 hrs cumulative total, po and im, reg and prn combined which indicates that it was over dosed 0.5mg Lorazepam by 42 mins.	Informed the patient. Informed the Ward Doctor. Observed the patient for any side effects and none evident.	All correct actioned followed and staff member did some reflection- no adverse effects noted	NA	Closed
GHC77732	15/10/2024	15/10/2024	10:30	ICT	Reablement Gloucester	Care agencies (home care)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administered when stopped	Administration	Aspirin	No					On visit today, medication in property was checked compared to the discharge summary. The Dossette box did not correspond to discharge summary as three medications had been stopped. Liaised with care manager to work out what was going on. On checking the packages in the property, three missing so unable to give to patient. Any medication brought home from hospital on discharge that was also in the dossette box had been taken back to the Pharmacy. Dossette box not issued on discharge. Medication was not available on the initial assessment last week as with the care managers who were sorting out the MAR charts for the carers.	Care manager was going to contact the GP and Pharmacy to get the missing medications as soon as possible. Dossette box removed from patients property to avoid further confusion. Patient informed that there was discrepancies with the medication and the therapist was liaising with the care team to sort it out.	Reviewed System1 and discussed with member of staff completing Datix. Identified that incident was carer error. All appropriate escalations completed at time of incident. Carer manager informed who remedied the issue.	0	Closed
GHC77825	17/10/2024	12/10/2024	15:00	Tewkesbury Hospital	Tewk Hosp- Abbey View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Ordering, collection or delivery	Tranexamic acid	Yes	500mg		Oral		A patient experienced haemoptysis, she had previously been prescribed Tranexamic acid by her oncologist for the same symptoms but had not brought the medication into hospital with her and it is a non-stock drug. Fair View pharmacy was closed. Local pharmacies do not stock Tranexamic acid, therefore I contacted the Pharmacy department at GRH who dispensed the medication and Free Wheelers delivered it. Later I discovered our hospital policy for acquiring medication OOH's is to call the Fair View OOH's number.	The patient received the medication in a timely manner and her symptoms resolved. I emailed Fair View pharmacy to alert them to my mistake and to apologise, I also notified the ward manager.	All staff made aware of the out of hours pharmacy by email and on the safety brief, Staff member involved has completed a reflection.	Email and safety brief utilised to inform all staff regarding out of hours pharmacy. Patient did get the medication in a timely manner, datix completed and fairview pharmacy informed.	Closed
GHC77830	17/10/2024	16/10/2024	17:30	ICT	ICT Glos HQR DN	South West Ambulance Service (SWAS)	Medication incidents	Medication incident involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Drug administration omitted / delayed	Administration	Morphine	No					Phone call received to triage regarding palliative patient struggling with pain and breathlessness. Paramedic on scene. DN called paramedic back and discussed symptoms and management plan. Paramedic advised that they are unable to give medication from the patient's "just in case medication" even if it is prescribed on a prescription chart. DN questioned this because previously paramedics have been able to give stat doses. Paramedic on scene advised they could only give meds from paramedic stock and not patient's own. Also said they only had morphine or ondansetron available and the patient was not nauseous or in pain.	At time of incident DN was speaking with GP and palliative care regarding plan for patient. Awaiting response from rapid response to see if they are able to visit. Called paramedic back as rapid response declined referral. Discussed symptoms again, paramedic said they have given Ondansetron as patient had woken and was nauseous. Paramedic asked roughly what time DNs would be visiting so they could reassure husband. Explained DNs would visit in next 45mins to r/v once new chart had been prescribed with palliative care input.	Patients records reviewed. Discussed with staff involved and Trust prescribing lead. Confirmed that the SWAST team could have given JIC medications with a community prescription chart.	No learning but may require a discussion with SWAST.	Closed
										Drug administration omitted / delayed	Administration	Midazolam	No									
GHC77877	18/10/2024	17/10/2024	09:00	ICT	Reablement TNS	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Docusate	No					1x Docusate Sodium and 1x Senna not administered to patient during morning visit.	Rehabilitation assistant on evening visit identified that the medication had not been given in the morning and contacted myself (Senior Rehabilitation Assistant). I spoke to our Senior Nurse Assessor who advised that I did not need to contact a GP.	Review of notes and actions. Thankyou for taking the time to report and action this datix. Patients missed doses are of huge importance, especially when constipation is of significant impact. Will follow up with reablement lead re missing dose. If SCNA provides advise in future, please ensure they document on patient records advice given to ensure oversight and GP's awareness if needed.	No further learnings	Closed
										Drug administration omitted / delayed	Administration	Senna	No									
GHC77883	18/10/2024	18/10/2024	07:00	The Vale Hospital	Vale Hosp- Peak View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Haloperidol	No					Nurse on early shift reported to me that patient was due to have haloperidol at 7am and it was not signed for on system1.	I contacted the bank nurse who was on the night shift but had no answer, voicemail left. Nurse called the ward back at 13:45 and informed me that she forgot to give patient the medication. System1 updated and ward DR present on ward and informed. Patient is currently settled so Dr has decided to carry on with next dose of haloperidol and no further intervention required. I discussed with Dr that I have a duty to inform patient of this however muyself and ward DR are both in agreement that this information is going to make patient more distressed and agitated when he is currently settled.	Incident reviewed and nurse has been asked to complete a reflection. It is also expected that the nurse will share any reflection and/or learning from this with colleagues. The training and development sister will pass on any learning to the wider team if it is felt to be appropriate. All actions taken at the time of the incident were appropriate and the patient was not harmed.	Medication outside of the normal drug rounds needs to be remembered by the team. This can be difficult to manage but is to be put on the safety brief to remind staff. All actions at the time of incident were appropriate.	Closed
GHC77891	18/10/2024	18/10/2024	15:00	ICT	Reablement TNS	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Docusate	No					Rehabilitation Assistant had not given Docusate during morning visit. It is also shown on the MAR sheet that Laxido has not been administered to the patient regularly and there is no evidence to suggest that the patient had declined this.	I informed TNS Reablement Lead.	Review of incident and themes across teams with medication errors/ not being administered. Have asked scna to follow up and identify any trends in any additional medication training that might need providing for the teams.	Thankyou for taking the time to report and action these incidents	Closed
										Drug administration omitted / delayed	Administration	Macrogol 3350	No									
GHC77904	18/10/2024	18/10/2024	08:20	LD Inpatients - Berkeley House	LD Inpatients - Berkeley House	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Propranolol	Yes	40mg	40mg	Oral	Oral	Initial prescription of Propranolol sent to pharmacy to order full supply On review by Pharmacist this was identified to not fall in line with current T3 (2018). Medication had been administered during morning medication round in error with limited supply on site. T3 (2018) had been uploaded as report opposed to MHA document so not easily locatable within RiO documents uploaded and in error checked prescription in line with T3 (2017).	Patient informed. Management informed. RC / Prescriber Dr Winterbottom informed. Request to dANP S.Eddy to stop prescription until can be reviewed. Staff working with Charlotte advised to monitor - no adverse effects noted at time of report. Physical Observations to be completed to support monitoring. Datix to be completed.	Incident reviewed and discussed in supervision and in MDT to ensure errors such as this do not occur again.	That the MDT needs ensure themselves they are referencing the most up to date documentation for patients when using these to guide clinical decision making.	Closed
GHC77919	19/10/2024	19/10/2024	00:09	Wotton Lawn Hospital	Wotton Lawn- Dean Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong patient	Administration	Lorazepam	Yes	1mg		Intramuscular		pt headbanging and not responding to verbal interventions and was in holds. Checked medication chart and drew up and administered 1mg lorazepam RT - given L leg. On return to sign observed wrong pt chart on display.	Duty Dr informed, unable to do physical observations as too agitated so non contact observations, continue to monitor for side effects, report any changes to duty Dr. Dr has Px Lorazepam	supervised drug round completed Staff aware how error occurred, engaged in reflection, and followed policy, ensured patient was monitored following incident Patient prescribed RT as this was required	staff to be more vigilant when administering medication, check RT with second nurse	Closed
GHC77984	20/10/2024	19/10/2024	08:00	The Vale Hospital	Vale Hosp- Peak View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Rivaroxaban	Yes	15mg	20mg	Oral	Oral	Patient prescribed Rivoroxiban 20mg at 08.00am medication round. Patient administered Rivoroxiban 15mg This was picked up by patient's relative who had asked about it in the evening when it was noted there was only a 15mg box in the patient's medication locker.	Ward Sister has spoken to nurse who gave out the morning medications for that patient. Staff nurse said that she did only give 15mg and not 20mg as prescribed. Staff nurse was not distracted at the time and read it wrong. Ward Sister has spoken to patient's daughter with apology. Ward Sister waiting to speak to patient when his wife arrives on the ward as requested by patient's daughter. Ward Sister has asked for staff nurse involved incident to reflect and to revisit some of the medication competencies on care to learn.	Incident and notes reviewed. Staff member has completed reflection of the incident and has re-done medication training. Further reflection will take place in clinical supervision with senior nurse. Changes to medication to be handed over as usual in handover	Communication between shifts can break down. Staff need to be clear in communicating any medication changes but also need to check medication chart at each drug round as per policy.	Closed
GHC77993	20/10/2024	20/10/2024	08:30	Stroud Hospital	Stroud Hosp- Jubilee Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Prescribing	Risedronate sodium	Yes	35mg	35mg	Oral		when completing a drugs round this morning I noticed that a medication that was prescribed was only supposed to be given once weekly and it was prescribed to be given daily. due to the patient being a new admission, I checked the paper drugs chart and it also said that it was once weekly last given on Friday.	Ward sister informed, Dr tasked to review.	Nurse noticed medication was prescribed for everyday when it should be a weekly administration. The paper drug chart had not been checked as the script had already been prescribed electronically and the paper chart filed away. Dr discussed and said Prescribing error yesterday with risedronate -appears was given 18/10/24 as well as yesterday Thus miss further dose in a week and restart in 2 weeks, drug chart has been amended and rewritten.	Staff nurse also spoken to and made aware about possibly looking at paper drug chart to check what the doctor had prescribed. Dr had 4 new admissions at the time this was written as they all arrived on the same day.	Closed
GHC78005	20/10/2024	20/10/2024	19:10	Charlton Lane Hospital	Charlton Lane- Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong patient	Administration	Promethazine hydrochloride	Yes	25 mg		Oral		One of the female patient A began escalating and was agitated, Nurses on the shift decided to go with PRN Promethazine 25 mg covertly with her. However she did not accept that in an ice-cream. Then patient A tried to smash the garden door with a chair. staff nurse tried redirect her but she turned towards the staff and tried to throw that chair to her . AT that point the nurse need to protect herself and put the cup of ice cream on the table next to her. Then a male patient B came and ate half ate a spoon of ice cream from it, which is of course mixed with PRN Promethazine for patient A.	Patient B was observed constantly on 1:1. Did not notice nay change in presentation. Done a set of NEWS2, scoring 1 for pulse:93 per minute. . informed duty doctor.	Physical observations obtained Reviewed by Dr Son informed	Nurse completed reflection Email sent to staff re: their responsibility when administering covert medications	Closed
GHC78025	21/10/2024	21/10/2024	10:00	CYPS Management & Admin	CAMHS - Admin	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Controlled stationary (medication related)	None (no harm caused by the incident)	Missing controlled stationary	Controlled stationary							A prescription was posted first class signed for to a pharmacy on 10th October, as is our policy. The prescription was never received by the pharmacy and so has got lost in the post.	Parent of the patient arrived at Evergreen house requesting a new prescription as they had run out of medication. A medic at Evergreen House provided a new prescription but requested the missing prescription is datixed as it is for a controlled drug.	Review of current process. No changes seen.	This is a mailing issue and internal processes are correct.	Closed
GHC78066	21/10/2024	12/10/2024	09:45	ICT	ICT Glos North South DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Ordering, collection or delivery	Other (unlisted)	No					Incorrect medication dosette boxes delivered to patient by Pharmacy. Patient's details on the front of boxes and same christian name but a different surname on the bottom of medication chart in the box.	Telephoned to report to Pharmacy who apologised and came straight out to patient's home to collect the medication. Pharmacy will return correct medication later the same day. Arranged with nurse visiting the next day to place in locked boxes.	Following the incident I have contacted Laura Bucknell chief Pharmacist for the trust to ask for advice with regards to whether this incident needs to be raised to anyone who oversees the pharmacy as this is the second time that this has happened with the same pharmacy. I am awaiting her response. HCA's are also concerned about prompting medications in case of errors.	I have read the trust policy for reablement workers for prompting medication. They complete medication risk assessment and MAR chart for each medication and feel that this is something we could adopt for this patient. I will discuss this further with Laura Bucknell and the community manager. All members of staff should be checking the medication against the medication list within the dosette box remember the 5 R's of medication administration.	Closed
GHC78085	21/10/2024	21/10/2024	19:20	Charlton Lane Hospital	Charlton Lane- Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Lorazepam	Yes	2mg	PRN 1 mg twice daily	Oral		PRN 1 mg was given at 09:02. It was given earlier at 04:54. At the time of the latter PRN administration the prescribed dose was 1mg lorazepam a day. The PRN prescription was to 1 mg twice a day, but a further dose was given in error at 16:00	Duty Dr was called and informed of the errors. He requested a set of NEWS2 observations, but the patient has remained too agitated and will not stay still for long enough. She has had a since, but this happened when she misjudged the speed of a four wheeled walker she had taken. She has been steady on her feet since and has not presented as drowsy. Duty Dr has asked staff to hold the 22:00 diazepam dose until further notice.	Managed appropriately	NA	Closed
GHC78127	22/10/2024	04/10/2024	21:00	Intravenous Therapy Team	IV Therapy Services	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Ceftazidime	Yes	2g	2g	Intravenous	Intravenous	Patient was prescribed IV Ceftazidime as a bolus, dose was given as an infusion by Rapid Response practitioner.	Red Lead Rapid Response informed on Saturday.	Discussed with Matron RR and to discuss incident with individual involved for reflection and learning.	IV medicines training and updates for all staff in RR to be booked. Topics to include e-learning medicines management on care2learn, IV Drug administration and medicines injectable resources. Include support and advice from IV Therapy Team.	Closed
GHC78139	22/10/2024	22/10/2024	20:00	District Nursing (ENDS)	ENDNS- Out of Hours DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Oxycodone	No					Visited patient for symptom control. Noted that stock sheets in patients home were not correct. Oxycodone 10mgs in 1ml had been stocked under oxycodone 20mgs in 2mls	Stock sheets altered and corrected. Update left on patients records. ' Reminder' added to patients notes	email sent regarding accurate documentation and the 6 r's	impact noted on staff due to increased EOL patients limited time know to service impacting rapport. limited registered staff therefore load unable to be shared for staff wellbeing	Closed
GHC78231	24/10/2024	19/10/2024	18:30	ICT	Reablement TNS	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Docusate	No					Rehabilitation Assistant did not administer morning dose of Docusate Sodium, other morning medication given.	Evening staff made myself (Senior Rehabilitation Assistant) aware.	Thankyou for taking the time to report and action this datix.	Lessons to be aligned to linked datix's and will be addressed in team this week.	Closed
GHC78256	24/10/2024	20/10/2024	09:00	ICT	ICT Glos HQR DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong patient	Administration	Insulin human	No					First time visiting patient for administration of insulin x2. Incorrect DOB on Humulin prescription chart. Unable to administer.	Spoke with band 6 M.F, advised i would see if patient able to self administer on this occasion. Patient administered herself with no issues.	Notes read Visiting nurse made GP surgery and prescriber aware of error. A new chart was organised and put into patients home.	Will discuss at next clinical governance meeting about confidentiality and ensuring that patients details are correct and double checked to avoid drug errors occurring. Prescribers responsibility to ensure they are following 5 R's.	Closed
GHC78330	26/10/2024	26/10/2024	12:00	District Nursing (ENDS)	ENDNS- Out of Hours DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Oxycodone	No					when doing patients syringe driver i noticed there were 4 missing vials of oxycodone	reported to management and datix completed	report of missing vials of oxycodone. notes reviewed and no obvious concerns for family in relation to drug misuse. nurses made aware to monitor during next visits as often medication placed in another location if seen OOH. any further issues/incidents to be escalated to management. checked notes and no obvious medication error noted.	impact of documentation on patient safety and monitoring of medications.	Closed
GHC78335	26/10/2024	25/10/2024	08:00	Forest of Dean Hospital	FoD Hosp- Woodland View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Insulin glargine	No					Medication reviewed on drug round 26/10/24.Discovered insulin not given on 25/10/24 Documented that patient had unsettled night and therefore sleeping. Breakfast not eaten so insulin withheld.	Datix completed Insulin given as prescribed on 26/10/24 BM's monitored QDS	patient reviewed by medical team, no ill effects from missed dose. increased monitoring of blood sugars for 24 hours insulin administered as prescribed going forward staff member involved met with ward manager and discussed decision making and sick day rules in diabetic patient.	clinical supervision with ward manager and revisit insulin guidelines	Closed
GHC78362	27/10/2024	23/10/2024	08:00	ICT	ICT Cotswold South 2 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Insulin glargine	Yes	correct dose	yes	Subcutaneous	Subcutaneous	Whilst writing up notes today, noted that the batch number and expiry date on S1 for last few days does not match the written prescription chart. Chart not signed on 25th October 2024	No action required today, chart photographed and datix completed	Human error, no harm caused to patient Various staff members duplicating information on to patient records which are incorrect. Not adhering to 6 Rs medicine management	Share at Team Time - ensuring meeting is minuted and shared to those who were not able to attend meeting	Closed
GHC78376	27/10/2024	27/10/2024	08:00	ICT	Reablement TNS	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Docusate	No					Laxido and Docusate not adminstered to patient by Rehabilitation Assistant.	Evening staff made myself (Senior Rehabilitation Assistant) aware and I have contacted Reablement Lead.	Review of notes Actions taken all linked to associated datixs Team member involved to receive additional support with meds management and supervisions arranged.	Lessons linked in preceeding datix	Closed
GHC78391	27/10/2024	27/10/2024	21:00	ICT	ICT Chelt Town Centre DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Stock balance recording errors / discrepancies	Oxycodone	No					Medication stock check in home. 3 more than documented of Oxycodone 20mg/2ml and 2 less documented of Oxycodone in 10mg/1ml. Stock sheets not correct and muddled not reflective of doses given. x2 drug charts in place. 1 crossed off for syringe driver and note on front to use new chart being used for stat doses. New chart no space to document stat doses given as finished.	Went through medication and stock checked with 2 people. Discussed issue with family believe confusion when every nurse visits. Seperated 2 different doses medication so do not become mixed. Have added to day ledger to take in more stock sheets to ensure clear documentation of medication. To have chart rewritten tomorrow as no space for stat doses and remove old charts from home.	9/12/24 All appropriate actions completed by clinicians. Complex EOL patient who has 2 syringe pumps in place and constant STAT doses and Sue Ryder admissions for symptom control. Had Metastatic Bile duct cancer with regular Palliative care Consultant medication reviews. Admitted to Sue Ryder again on 30/11/24 due to uncontrolled symptoms and has since passed away	All actions completed but I will e mail Consultant to arrange debrief for staff as very complex patient to manage due to symptoms.	Closed
GHC78397	28/10/2024	25/10/2024	11:00	ICT	Reablement Cheltenham	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Lorazepam	Yes	1Mg	1/2 Mg	Oral	Oral	Medication error - 1MG tablet administered as opposed to 1/2 MG.	TCF Family to ask what happened. I called RA to ascertain facts. Advised family to call GP/111 for advice as I couldn't get hold of RA immediately. Relayed info back to family from RA once spoken with her. Family called 111 for guidance/advice.	records and file reviewed - discussion with staff involved discussion with training and development team re meds / pill cutters / policy medication refresher training developed and disseminated to the team	discussed with team and training and development leads - meds refresher training developed and being rolled out countywide	Closed
GHC78424	28/10/2024	25/10/2024	17:46	Long Term Conditions	Heart Failure	Pharmacy- community	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong drug / medicine / item	Pharmacy	Prednisolone	Yes	Multiple meds as dosette trays	Multiple meds as dosette trays	Oral	Oral	Callback requested from son. Mum has dosette trays delivered weekly. Son has noticed that dosette tray the w/c 23/9/24 was for another patient and mum took these tablets all week. As far as he is aware she only took wrong trays for 1 week only but they are not sure as they do not always look at slips in trays. During this time she was had a period of being very unwell with confusion and sleeping all the time. Back on normal meds now and tray appears correct.	I have advised he call pharmacist asap and flag this med error. Had U&E's/FBC 17/10/24. Not a HFS error, external Pharmacy error, Laura Bucknall Medicines Management Lead added as investigator.	Reported external to GHC	Highlighted to pharmacy external to GHC	Closed
GHC78458	29/10/2024	29/10/2024	10:20	Wotton Lawn Hospital	Wotton Lawn- Inpatient Physio	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Administration	Other (unlisted)	Yes	full 0.5ml injection	correct dose of wrong drug given drug requested not given	Intramuscular	Intramuscular	Giving Covid and Flu vaccinations at WLH. Discussed both and patient wanted Flu vaccination had spoken about recently having covid and did not want this vaccination just yet. Gave Covid vaccination instead of flu. Colleague spotted error and informed me after staff member had left the clinic. Please note cannot find an email address for the member of staff so cannot add. cannot send datix without. have added email of manager in the space so i can report my error	Went to find the staff member. Told her what i had done in error. Informed her i would complete a datix and if she wanted to take this further she was entitled to do so. Staff member wondered if the vaccine would make her feel unwell. Covid last approximately 2 weeks ago. Reassured it would be unlikely. Asked when she should have her flu vaccination. Advised to leave it this week and to consider having next week in case she was unwell following my error datix completed.			Being Reviewed
GHC78465	29/10/2024	29/10/2024	10:00	ICT	ICT Glos North South DN	GP	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong route	Prescribing	Hydroxocobalamin	Yes	1000microgram in 1ml	1000microgram in 1ml	Intramuscular	Intramuscular	Hydroxocobalamin drug chart not completed correctly. Drug route written as IV. Should be IM	Administered last loading dose. via mars chart. Datix Handed over in hand over	To be re-iterated in handover the importance of checking drug charts and correct completion of MARS Charts following policy	To ensure all nurses who are administering medication are competent with MARS CHART Completion.	Closed
GHC78480	29/10/2024	28/10/2024	22:00	The Vale Hospital	Vale Hosp- Peak View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Administration	Senna	No					Patient has reported to me that her 10pm medications were incorrect. She reports that the nurse entered the room without the drug trolley. Her wristband was not checked. She does not recall if she was asked to identify herself. The patient reports the nurse handed her a pot with two 'chalky brown' tablets in it. The patient is very aware of her medications and challenged the nurse that these were not her normal medications. The nurse insisted she take them so the patient did. The patient then asked the nurse to come back and give her her regular medications. She stated she was given two pills then not her usual 3 and was aware that her ramipril was not in the pot.	1. Listened to the patient and apologised for the incident. 2. I showed her two senna tablets which she confirmed were the initial tablets she was given. The patient is not prescribed this medication due to diverticular disease. Ward Doctor to be tasked to review. 3. I assured the patient we would check her blood pressure and may consider giving tonight's dose of ramipril earlier if needed. Doctor to be tasked about this 4. I asked if she would like me to ask the night nurse not to work with her again. The patient stated she did not want the nurse providing care for her again. 5. I asked if there were any other actions she would like to happen from here. The patient stated she was very happy with our response. 6. Nurse to be emailed to provide a reflection on the incident and bank team to be updated following this for any additional support required. 7. drug chart checked to confirm medications. Concern that medications have	Incident reviewed. Support offered to bank nurse. All action taken appropriate post medication incident. Medication competencies with bank staff are ongoing to ensure correct procedures are followed across the trust.	All staff need to follow the correct procedures for identifying a patient and administering the correct medication during a medication round. Support for bank staff in the form of completing medication competencies is ongoing.	Closed
GHC78520	30/10/2024	28/10/2024	16:00	ICT	ICT Cotswold South 1 DN	Self-care	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Preparation by administering clinician(s)	Morphine	No					EOL new patient GP dropped off more Midazolam and Morphine ampoules to the house following my intial visit to patient as there would not have been enough Morphine to set up driver and only 5 x ampoules of each JIC med prescribed originally. When I returned to set it up I could not find the original ampoules of Morphine, Midazolam and Glycopyrronium that had been in the house when I left to collect the driver equipment. I could only find the ones the GP had dropped off. I asked partner if he had moved them and he said he had put them on the fire as he thought the boxes were empty (the boxes had been plain white with pharmacy label on and ampoules were loose wrapped in tissue inside). Documented on the stock sheets that this had happened and new stock that GP had left there I added to the stock sheets.	Following setting up the driver, only 1 x Morphine ampoule left in the house and no Glyco so I explained to the GP what had happened and asked him to prescribe further ampoules of JIC meds to ensure enough in house in case needed overnight for stat doses and for driver tomorrow . Partner arranged to collect the JIC meds form the pharmacy that evening.	Notes reviewed , all appropriate action taken at time of incident	This was a genuine error and luckily no one was hurt when the boxes were chucked on the fire. Clearly this could have been dangerous and is not something we would encourage to do. Medications should be disposed of correctly by a pharmacy. Family already realised this, patient has now passed away.	Closed

GHC78567	30/10/2024	29/10/2024	15:30	ICT	ICT Forest South DN	Pharmacy-community	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Pharmacy	Midazolam	No					Attended for routine blood test as requested by GP. Upon arrival patient had ?stroke over weekend, rapid response and GP had been visiting and placed patient EOL. Discussed with care manager checking in JIC medications for patient and upon checking noted that Midazolam on the pharmacy label was prescribed 10mg/5ml amps but upon checking the midazolam it was in amps of 10mg/2ml.	Discussed with SCN and datix completed	pharmacy responsible made aware senior nurse informed correct information written on stock check sheet fed back to the pharmacy. Due to end of month the prescription is boxed away but they are going to chase. A note is also on the patient's pharmacy records and the pharmacist and dispenser will be aware.	all appropriate action taken at time of incident and pharmacy contacted and spoken with and made aware of incident	Closed
GHC78586	31/10/2024	30/10/2024	12:00	ICT	ICT TWNS DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Morphine	No					-patient discharged from Tewkesbury community hospital over the weekend -attended patient to check in JIC medications -previous notes suggest say nurse unable to locate JIC medication -on arrival patient son reports found a bag with medication in, when checking in medication 1x ampule morphine sulphate missing from stock -10 ampules documented as TTO, 9 ampules in box -no stat doses documentd in folder or system one	-searched property with son, unable to locate -checked in stock at property in yellow folder -Band 6 aware -telephoned Tewkesbury community hospital to enquire regarding stat dose	Morphine ampoule missing on assessment Discussion with Tewkesbury hospital who discharged patient, no stat doses given prior to discharge and no evidence of stat dose being administered on drug chart. No harm caused to patient Investigated appropriately by nurse who discovered missing ampoule and escalated in accordance with policy. Patient RIP with no ill effects found or suspicion and expected death No further action needed	No lessons learnt, everything carried out appropriately Findings to be carried out in team time	Closed
GHC78595	31/10/2024	31/10/2024	10:50	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong / unclear dose or strength	Administration	Other (unlisted)	Yes	unsure of dose received	unsure of dose received	Subcutaneous		Patient is encouraged to administer own insulin once it has been prepared for her if she feels well enough to do so. Patient attempted to administer Humulin I today however did not receive the full dose, had reduced the pressure on the pan once inserted so the safety cap came over, unsure how much of the dose she received, insulin present in the safety cap. I then administered the second insulin. I had requested finepoint (non safety) needles previously to support the patient to be more independent with administering her own insulin successfully. I have asked the care lead to see if these have arrived for us to try with the patient.	Apologised to the patient, advised I would ask about the non safety needles to enable her to continue administering her own insulin. I administered her second insulin to avoid this happening again.	Senior community nurse visited following incident on 6/11/24 and reviewed patient technique and reports that 1 off incident. DN team to continue to preform ongoing reviews. Patient has safety needles which are being used.	Continue to monitor patient technique for Insulin administration	Closed
GHC78606	31/10/2024	09/10/2024	20:00	Charlton Lane Hospital	Charlton Lane-Chestnut Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Morphine	Yes	5mgs		Oral		Staff not documented in Controlled book of the MST medication that was administered which was signed on Rio given, which makes the total number of the tablets left one less in records.	Informed the staff Bank staff to inform the nurse who administered.	Informed the staff Bank staff to inform the nurse who administered. there is a list up in one of the medication cupboards, where everything is explained depending on medication	remind bank and agency nurses of conrtol drugs policy	Closed
GHC78635	01/11/2024	01/11/2024	10:30	Sexual Health Service	Sexual Health Integrated ISH	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong method of preparation	Administration	Sodium chloride	Yes	3.5ml	3.5ml	Intramuscular	Intramuscular	Patient attended for GC treatment , positive from home test kit. Full history taken. Medication – ceftriaxone 1 g and Lidocaine 5ml bottle (3.5ml needed) with expiry date and lot number checked with myself (nurse) and student nurse prior to administration . Given permission for Student to draw up.Aware Lidocaine 3.5ml only needed The dose was rechecked. Medication drawn up in room with patient. After administration – realised medication mixed with wrong diluent 0.9% Sodium Chloride (3.5ml). (normally used for wet slide reading) Discussed with consultant in clinic -likely no adverse reaction possible as historically medication were mixed with this before local analgesia was introduced. The patient would likely be in more pain in comparison to having mixture of numbing agent lidocaine.	Patient informed at time in clinic and apologises given. Reassured efficacy of medication remains the same. Patient aware can contact us if any concerns Lead nurse informed. Datix completed.	Clinician involved with the error almost immediately identified the error herself. Advice was sought in a timely manner from the consultant. The patient was correctly advised of this error. This Datix was completed appropriately.	The student involved with this incident was supported by the clinician that she was working with at the time and subsequently by the Trusts Practice Education Facilitator and the University. Medication that requires drawing up should be drawn up in a clean utility where available; this may have stopped this incident occurring.	Closed
GHC78705	02/11/2024	02/11/2024	12:00	ICT	ICT Cotswold South 2 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Levomepromazine	No					Longfields staff had requested community nurses to review situation with JIC meds as Levomepromazine was not in the property but was prescribed on the drug chart. Could not see that the disparity with the Levomepromazine had been looked into so checked this today. JIC meds chart in the property and all signed. Confirmed Levomepromazine not in the property, Hortons pharmacy has received no scripts from the surgery for any JIC medications. JIC medications were supplied upon discharge from the hospital, was given Haloperidol for nausea and/or agitation however this has not been prescribed on a drug chart. All other JIC medications correct and present Discussed with shift lead who advised to contact out of hours GP to prescribe Levomepromazine in case it was needed with it being first line. Medications look to have been stock checked within the last month by community nursing team.	Discussed with shift lead Called out of hours GP to prescribe Levomepromazine and water for injection, script was sent to a local pharmacy. Asked family to pick it up today and take back to the property A more experienced nurse is booked to visit on Monday and double check situation with JIC medications and review hospital discharge summary if there was a reason for Haloperidol to be prescribed for nausea instead of Levomepromazine	- Good escalation by visiting nurse and correct medication with correlating chart now in situ. - No harm caused to patient.	- Identified that patients being discharged from GWH are being discharged with Haloperidol as first line anti emetic which differs from our trust policy. This was discussed in our leadership meeting and will be addressed with GWH in an effort to minimise errors/delays in patient care. - Disparity not picked up/rectified during NP assessment or when stat doses had been given previously, wider team may benefit from reminder to thoroughly cross check all charts and JIC meds upon receiving patients from hospital.	Closed
GHC78721	02/11/2024	02/11/2024	18:00	Cirencester & Fairfrd Hospital	Ciren Hosp- Coln Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Administration	Dalteparin	Yes	5000		Subcutaneous		Deltaparin has been administerd , patient was not prescribed for it. Patient was prescribed with Apixaban.	Incident spotted on the site itself, observations taken, NEWS of 0, patient been watched for the whole shift, patient is stable. Ward Doctor informed. Patient and family informed , verbal apology given for the drug error.	all actions takena s part of medication errors policy	the staff is aware of her actions and aware of the improtance of if interupted to discard and restart the dispensing of medications	Closed
GHC78728	03/11/2024	03/11/2024	10:15	Criminal Justice Liaison	Criminal Justice Liaison	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Information / advice to patient not given / wrong	Monitoring / follow-up of medicine use	Promethazine hydrochloride	Yes	50mg		Intramuscular	Intramuscular	Patient received Rapid Tranq prior to being arrested and taken to Compass house. Policy states needs 4hrs of observation following RT. This has not been followed.	Discussion with Ward to obtain details of RT and timing. Discussion with Custody Sgt. Further discussion with ward following non-detention at custody.	Discussion regarding this had with Matron	Process altered to provide support to patients in these situations going forward	Closed
GHC78757	03/11/2024	26/10/2024	17:01	MIIUs	MIIU- Forest of Dean	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Prescribing	Phenoxymethylpenicillin	Yes	250mg Four times a day	250mg Twice a day	Oral	Oral	Patient (2 years old) seen 26th October for tonsillitis. Phenoxymethylpenicillin prescribed 250mg QDS 10 days. Mother attended with different son today (4 years old) for similar symptoms and issued Phenoxymethylpenicillin 250mg BD 5 days. On returning home she was unsure why her younger son seen on the 26th was prescribed the same dose medication four times daily, whilst her older son was advised to take it only twice daily. Patient should have been prescribed the same dose as her older son. Medication error therefore identified.	Manager informed BNF reviewed and dosage as follows: Child 1–5 years 125 mg 4 times a day for 5–10 days, alternatively 250 mg twice daily for 5–10 days. Toxbase reviewed but unclear of toxic dose over 8 day duration. Discussed with OOH GP who also felt this was unclear. Discussed with Paeds Registrar Dr Mathews GRH who advised she would look into the dose and contact mother directly to advise whether the child would need to be seen or is safe to remain at home. Appologised to mother, confirmed patient is feeling much better and has been fine whilst on this dosing regime. Advised to contact unit at 16:00 if no contact from paeds doctor. Mother contacted unit to advise of no contact Paeds nurse in charge contacted who found Dr Mathews and advised will	Patients Mother was contacted by Paeds GHFT for reassurance Practitioner supported and reflective account written All pre-populated doses removed from systemone electronic prescribing Implemented double checking processes when issuing from unit	Ensure all medications dispensed from unit are double checked	Closed
GHC78780	04/11/2024	23/08/2024	10:00	CYPS/CAMHS - Core CAMHS	CAMHS Core	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Pharmacy	Olanzapine	No					error in writting the script. prescription copied from the previous written script which seemed to look like 7.5 mg but the actual dose was 2.5 mg.	parent called to notify the error on the script. patient has not received the higher dose.	-Patient and family contacted to inform of error and to check if incorrect dose not taken and any concerns around side effects. -Advised the importance of reviewing the clinical notes and ensuring that drug doses are confirmed rather than assuming a dose based on a previous prescription if the handwriting is unclear.	-To be clear about prescriptions and doses and to access the clinical record especially if asked to prescribe for a patient not under one's care.	Closed
GHC78783	04/11/2024	21/10/2024	14:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Diazepam	No					During the October missed dose Audit a missed dose was identified during the 14:00 drug round.	As this was agency nurse staff bank has been contacted to request a reflection from the Nurse	Reflection provided by agency nurse demonstrating learning	No further lessons identified	Closed
GHC78841	05/11/2024	05/11/2024	09:30	Early Supported Discharge	Early Stroke Discharge ESD	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Monitoring / follow-up of medicine use	Aspirin	No					Patient took all of todays medication, breakfast, lunch and diner medication for next day and morning and lunch of thursdays medication	Rehab assistant completed observations (blood pressure/pulse), contacted doctors surgery who called back within the hour. she agreed he had safe dose and did not need any further medical intervention, said blood pressure ok, no medication for rest of day and to restart tomorrow but to review medication delivery system and package of care. Liaised with line manager. removed medication out of reach/sight with patients permission. Therapist to visit next day to review issues	Member of staff spoke with myself and had correctly identified that patient was not in any immediate danger from taking more medication that he should of and phoned the GP who verified this and advised the patient not take any more medication for the next 24 hours. Patient was discussed in MDT - a referral has been made to adult social care for a package of care to support taking of medication, a referral has been made to telecare for a pivotel dispenser, the ESD team is going into the pt twice daily to support taking of meds until package of care is set up however this is not adequate to meet their needs as medication needs to be taken 4 x daily. We are also speaking to the GP to see if any medication can be amalgamated. Referral to safeguarding has been discussed.	We have been supporting medication needs rather than therapy needs. Patient was discharged to ESD from the acute and they reported that he had a SAMS trial and had passed this so not sure what more could have been done to check that he was independent with taking his medication prior to coming to ESD.	Closed
										Wrong time / frequency	Monitoring / follow-up of medicine use	Amlodipine	No									
										Wrong time / frequency	Monitoring / follow-up of medicine use	Carbocisteine	No									
										Wrong time / frequency	Monitoring / follow-up of medicine use	Lansoprazole	No									
										Wrong time / frequency	Monitoring / follow-up of medicine use	Lansoprazole	No									
										Wrong time / frequency	Monitoring / follow-up of medicine use	Losartan	No									
										Wrong time / frequency	Monitoring / follow-up of medicine use	Montelukast	No									
										Wrong time / frequency	Monitoring / follow-up of medicine use	Nicorandil	No									
										Wrong time / frequency	Monitoring / follow-up of medicine use	Quinine	No									
										Wrong time / frequency	Monitoring / follow-up of medicine use	Tamsulosin	No									
GHC78853	05/11/2024	05/11/2024	19:50	Charlton Lane Hospital	Charlton Lane-Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong patient	Administration	Diazepam	Yes	NA		Oral		Patient A started to escalate, nurse given patient A's night medications covertly in a custard, but Patient A was not settled, was mobilising continuously, when staff tried to support her to take the custard Patient A verbalised are you 'poisoning me' and started to escalate. Therefore staff gave her sometime to settle and she had few spoon of custard when staff kept a distance from her, Patient A continues to mobilise and staff were observing her as she got the custard with medicine in it. Unfortunately she sat next to another Patient B and gave her half teaspoon of custard quickly before staff can intervene.	Patient A was redirected from Patient B, custard was taken away from Patient A. Physiological observation done for Patient B (BP 134/75, HR 75, RESP 20, SPO2 99,Temp 36.5) and wasn't scoring for anything. Patient B seems to be in her usual presentation, no allergic reaction observed. Duty doctor informed. Family informed	Managed appropriately Updated to include that family were informed	NA	Closed
GHC78897	06/11/2024	04/11/2024	16:30	ICT	ICT Forest North DN	Pharmacy-community	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Pharmacy	Glycopyrronium bromide	Yes	200mcg		Subcutaneous		Attended for SOS stat dose. Counted in JIC medication and discrepancy. Pharmacy label stated 5 ampoules of glycopyrronium dispensed in box but when counted for stock sheets in there were 7 ampoules.	Correct amount noted on stock sheets Discussed with SCN To contact dispensing pharmacy	Correct actions taken dispensing error dispenser notified recorded correctly within patient record	correct actions taken - no further learning identified	Closed
GHC78914	07/11/2024	06/11/2024	22:30	LD Inpatients - Berkeley House	LD Inpatients - Berkeley House	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong time / frequency	Administration	Flucloxacillin	Yes	500mg		Oral		The medication chart was incorrectly read, resulting in an extra dose of Fludoxacillin 500mg antibiotic being administered.	When it was noticed that the error had been made, the staff working with the patient were advised by the nurse, so they could watch for any reaction. The duty doctor was contacted and the situation was discussed with them. They advised to complete a NEWS2 assessment, this was done and the result was zero. Entries were made in the notes of the patient by both the nurse and the doctor.	Discussion with staff member during supervision, agreed actions to ensure greater scrutiny of prescribed medications.	That the staff member will increase scrutiny of prescribed medications before adminstration.	Closed
GHC78933	07/11/2024	07/11/2024	09:30	Assertive Outreach	AOT West	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Haloperidol decanoate	No					Came to attention of Nurse that Depot medication had not be administered to patient. Patient has missed 2 doses of medication over a 4 week period. Last time depot was administered 28.09.24 and was due 12.10.24, however was not carried forward in diary and not followed up therefore was missed. Came to the attention of the team today.	Nurse discussed with Consultant who advised to raise datix and retitrate patient back on to prescribed medication. All of team informed, Medication to patient administered, documented and diarised in appropriate places.	All staff reminded of the importance of the use of the team diary and how all medications/depots and visits need to be put in this to be allocated in the morning meetings	Lots of new staff members in the team - teaching session provided by manager and consultant around the AOT model to take place at team away day. Medication lead in the team to check the diary/depot charts weekly to check they are correct in the diary	Closed
GHC78954	07/11/2024	02/11/2024	10:00	Psychiatric Liaison	MH Liaison Alcohol Inpatients	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Prescribing	Diazepam	Yes	30mg		Oral		CIWA initial 24 hours commenced 1/11/24 13:49 scored on 2 occasions requiring 7mg diazepam at 13.52. Scoring for tremor, anxiety, tactile disturbances and headache. An Intermediate level detox was also commenced at the same time as the initial 24 hours 3x 10mg doses were given at 13:47, 22:27, 08:39.	Discussion with ward doctor and nurse looking after patient regarding this. Both regimes were stopped and a new initial 24 hours was commenced to accurately capture withdrawal symptoms.	GHC 78954 INC 13952 02.11.2024 Case regarding a CIWA that had not been done correctly. First CIWA had not logged as being done onto worklist manager. Therefore, a second CIWA had been given. Helena-Rose says this highlights a big issue that you can prescribe, close and re-prescribe. Suggests we use this case as an example to raise with EPR team. Helena Rose is looking further into this – drug chart immensely confusing. Action: Vivek to do some factfinding regarding how often these occurrences happen. Need for better IT/Software systems (used by other NHS Trusts) Plan for Vivek to raise with Michael Thomas ED Consultant and will update action to Datix.	For identification and resolution within GHFT. ED practice education team aware. Vivek Chaabra actioning.	Closed
GHC79010	08/11/2024	07/11/2024	12:00	Intravenous Therapy Team	IV Therapy Services	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Prescribing	Ceftazidime	Yes	2g	2g	Intravenous	Intravenous	Patient discharged from Ward 7A with incomplete drug chart, dose and duration prescribed but drug name not stated	Drug confirmed on discharge summary, colleague Co ordinator contacted ward dr on 7A to confirm drug and dose. Drug chart amended accordingly	Failed discharge with incomplete drug prescription chart. IV nurse reported and fed back to the discharge team. Patient did not miss a dose of IV antibiotics as prescriber was able to prescribe the drug needed to administer the dose needed for the patient.	Discharge team and prescriber should check patients documents including drug prescription chart is correct before patient is discharge.	Closed
GHC79022	08/11/2024	08/11/2024	09:00	ICT	ICT Forest North DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Drug administration omitted / delayed	Monitoring / follow-up of medicine use	Buprenorphine	No					* Patient discharged from hospital 15/10/24 for daily insulin, leg dressings and weekly Buprenorphine patch (due 22/10/24) * Patient is palliative * Palliative care nurse visited yesterday and discovered patient had a Buprenorphine 5mcg patch on his back dated 8/10/24 * palliative care nurse called through to DN referral centre	* Palliative care nurse has notified GP and requested prescription chart for nurses to change patch. * patient has had 2 full skin assessments since discharge and not documented patch * Patient has Reablement package of care * visit scheduled to assess tomorrow and to schedule ongoing patch changes	12/11 CNL review. Medication ordered an in place. visits allocated to change patch. No referral from hospital on discharged re medication patch.	Thank you for your datix. Learning discussed at team time.	Closed
GHC79067	10/11/2024	10/11/2024	01:00	District Nursing (ENDS)	ENDNS- Out of Hours DN	GP	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Prescribing	Glycopyrronium bromide	Yes	200mcg	200mcg	Subcutaneous	Subcutaneous	visited an EOL patient for a stat dose overnight, assessed patient and gave appropriate stat doses. On tidying up and finishing documentation I noticed that drug chart did not have a start date written on it.	OOH GP phoned for verbal confirmation and asked them to send it in writing to email to attach to record. datix completed. from reading S1 notes I can see documentation from GP that JIC meds and charts were issued on 7/11/24	Nurse visited an EOL patient for a stat dose overnight, assessed patient and gave appropriate stat doses. On tidying up and finishing documentation I noticed that drug chart did not have a start date written on it.	To review chart pre doses of medication - to complete appropriate checks reminder given to team. Nurse recognised and got verbal order followed policy for this. Patient died shortly after GP made aware to get new chart but patient deceased before this could be done. GP wrote chart no district nurse input until nurse visited overnight - no stock checks or opportunity to check chart by day district nurses. Recently mentioned in CNL meeting regarding checks to drug chart for symptom control doses	Closed
										Drug chart errors - not signed, recording, other	Prescribing	Morphine	Yes	2.5mg	2.5mg	Subcutaneous	Subcutaneous					
GHC79084	10/11/2024	08/11/2024	18:00	ICT	ICT Stroud Cotswolds DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Insulin human	Yes	18 units	16 units	Subcutaneous	Subcutaneous	I visited on Saturday 09/11/24 in the evening for the patient's evening dose of insulin. I noticed that the wrong dose had been administered the evening before (08/11/24). The patient is on a sliding scale - patient should of been given 16 units of insulin, but was given 18 units.	Reported to band 6 shift lead. Was asked to take photo's of the drug chart and to datix.	14/4/25- I have been unable to trace the original insulin drug charts that the incident relates to, therefore I am unable to identify circumstances and clearly advise on learning.	14/4/25- trained staff have though been reminded of the importance of checking medication doses of patients who are on sliding scale insulin and to ensure it is recorded accurately.	Closed
GHC79087	10/11/2024	08/11/2024	12:00	ICT	ICT Cotswold North DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong time / frequency	Preparation by administering clinician(s)	Metformin	Yes	1g		Oral		Visit to patient to support with wound care and manual handling Call in from NOK prior to visit reporting patient had B.O and requiring assistance. On arrival, Daughter of patient showed the dosette box missing 6pm dose of medications, reports had been given at lunchtime (12pm) by carer. Dossette box med not in correct container , hand written for 6pm dose on box in lunch time slot.	Reporting this incident in retrospect, the patient died on 10.11.2024 Had been seen by GP on 8.11.24 and prescribed JIC meds prior to incident Photos taken of dosette box Explained to NOK may have been the reason for B.O this pm as additional doses of Sodium docusate given early, also had Metformin MR early and side effect of this can be loose stools. Spoke with clinical lead and message passed to reablement workers re dosette box, to prevent further drug errors Contacted GP surgery and added to triage list for patient to be reviewed post additional doses of medications. Visit booked next day to review patient for wound care and support.	Thank you for the datix- Correct actions taken by visiting nurse. Picture of dosette box reviewed and can see that this was unclear and confusing for care team visiting. Patient EoL and died 10.11.24 which was not related to the medication error which was noted on the 8.11.24.	Incident has been discussed with the reablement lead and she will discuss/ share this with the team	Closed
GHC79089	10/11/2024	10/11/2024	11:30	Crisis Resolution Home Treatmt	CRHT Chelt & Tewks	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Monitoring / follow-up of medicine use	Dapagliflozin	No					Pt given diabetic Forxiga 10mg medication not prescribed from them, from General hospital to take home. Pt given 2 types of medication to take home from General Hsp with someone's details. Forxiga 10mg and Laxido	Contacted the General Hsp ward for clarification. Medication taken away by CRHTT staff to be disposed.	Staff contacted GHT ward and advised of error Staff removed of medication and disposed of per POPAM Checked with GHC pharmacist - nothing further can be done from GHC PALS number provided	None	Closed
GHC79105	10/11/2024	10/11/2024	21:20	ICT	ICT Stroud SevernHealth DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Prescribing	Morphine	No					Palliative patient needing stat dose for pain. Unable to administer morphine as chart dated and signed but no dose written on chart.	Rang OOH GP provided dose of 2.5mg - 5mg morphine verbal order. GMC number taken, Email received. GP OOH attending to write up syringe driver will sign drug chart at property. Patient comfortable on leaving	Palliative patient needing stat dose for pain. Unable to administer morphine as chart dated and signed but no dose written on chart. Visiting nurse acted promptly and rang OOH GP provided dose of 2.5mg - 5mg morphine verbal order. GMC number taken, Email received. OOH's GP also visited to write up a syringe driver. Stat dose administered by visiting nurse.	No harm to patient as verbal order was received from the OOH's GP so care was not delayed. To ask all nurses in the team when collecting JIC medications charts to check a dose is written on the chart. To also check the chart is signed and a start date has been added.	Closed
GHC79153	11/11/2024	11/11/2024	18:00	ICT	ICT Glos North South DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Medication storage issue	Disposal	Morphine	No					Asked to collect a Syringe Driver box from a patient's family after patient deceased. On returning to base to clean out and replenish box, found the patient's medication inside, some controlled and some not. Stock was counted and checked by colleague and then all returned to pharmacy locally.	Stock checked and counted by a colleague and found to be correct according to the patient's prescription charts and returned immediately to pharmacy.	Thank you for bringing this to our attention. This will be brought up at hand overs to make staff aware to check contents of the Syringe driver box prior to removing from the home to check that there are no medications been placed by family members.	To be mindful when removing syringe driver boxes. To always ensure that there is no unused medication in the box and to also remind family that they are required to return unused medication to the pharmacy for disposal.	Closed
GHC79173	12/11/2024	12/11/2024	06:30	District Nursing (ENDS)	ENDNS- Out of Hours DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Diamorphine	No					Visited palliative patient to administer stat dose medication. On stock checking the diamorphine 30mg, 5 vials were missing. There should have been 32 vials, but there were only 27. I then checked the stock sheet for the diamorphine 10mg, there should have been one vial remaining but there weren't any.	Checked with patient if he knew of another location the diamorphine could have been placed. Patient unaware that drugs would have been placed anywhere else. Checked through all other injectable medication but still unable to locate. Patient checked through cupboard and drawers but not there. Stock sheet amended to reflect correct balances.			Being Reviewed
GHC79183	12/11/2024	12/11/2024	08:30	ICT	ICT Cotswold South 1 DN	Self-care	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Paracetamol	Yes	4x 30mg/500mg	2x 30mg/500mg	Oral		Visit to patient for morning Insulin. Patient currently on antibiotics for UTI, had blister pack of asprin which appeared to think ?same thing. Discussed medication and checked Dosette box, found to be taking morning and lunchtime tablets together - taking double dose of Zapain 30mg/500mg as well as extra Asprin - reported to take it sporadically. Reports has been doing this for some time	- Obs checked - Discussed medication and when should be taken - Phone call to G.P surgery and urgent call back requested - Phone call from pharmacist at surgery - they are going to contact pharmacy to see if lunchtime Zaipain can be taken out - Has other boxes of paracetamol - advised should not taken this as already has in dossette box - Worsening advice given	Reviewed notes - good response to patient giving medication incorrectly Worked with GP to resolve the issue	check medication management and review dossette box need more regular with some patients. Add for regular review to future appointments	Closed

GHC79202	12/11/2024	12/11/2024	09:00	PICU	Wotton Lawn-Greyfriars PICU	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong drug / medicine / item	Administration	Promethazine hydrochloride	Yes	25mg		Oral		Staff nurse was approached in the clinic by a HCA, who advised that they where feeling sick and enquired as to whether they could administer any medication to them to help with their sickness. Staff nurse advised that then could administer promethazine, which may help, however advised that this may cause drowsiness. HCA accepted the 25mg promethazine and after around an hour became very drowsy and in light of this had to remain in staff areas as it was felt unsafe for them to complete duties.	HCA who had taken promethazine offered a safe space away from clinical areas to manage the drowsiness. Staff nurse who had administered medication spoken to by ward manager to have a reflective discussion surrounding the incident. At this point staff nurse advised that this incident would be classed as a medication error. Staff nurse advised that she can not administer medication until a reflective piece has been completed and signed off. Staff nurse also advised that she will be required to complete three supervised medication rounds, prior to be allocated to meds. Hopefully , this process will identify any required learning and ensure that staff do not administer medication to other staff members. Concerns escalated to MM, who has sent an email to all ward managers to ensure information is shared surrounding why this should not happen across the hospital.	Reflective discussion completed with both members of staff effected by the incident. Further highlighting that under no circumstances is the medication in the clinic for staff use. Welfare check completed for the staff member who was give the medication. Nurse who administered the medication was supported to complete three supervised medication rounds with senior nursing staff. A reflective account was also completed. Support, education and regular supervision provided by ward management team.	Email sent to team to highlight why medication within the clinic can not be given to staff. Email also sent to all qualified nurses to highlight why then must not give medication from the clinic to staff members, highlighting professional accountability.	Closed
GHC79208	12/11/2024	11/11/2024	10:50	Montpellier Secure Inpatients	Montpellier Low Secure Unit	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administered when stopped	Administration	Chloramphenicol	Yes	1 application to each eye		Optical		Patient on stage 1 medication self administration. Whilst administering his morning medication in the clinic patient was asked what other medication he needed besides his tablets in his chemi pack. Nurse asked "inhaler" and he answered "yes and my eye drops". Nurse asked about this and he said for his infection. It was said in handover that he had conjunctivitis last week. He took the eye ointment medication in his box and administered this before the prescription had been checked. Prescription then checked and this medication prescription was discontinued 1 week ago.	Informed patient he had taken medication without prescription. That this medication is usually prescribed for no more than a week and that he could re-infect his eyes by using the same tube of ointment. Nurse has spoken to supervisor re medication error protocol. All nurses to be aware that patient may administer medication off prescription and they must check first or not allow access. Medication was disposed of.	Nurses reminded to check prescription before allowing access to medication which is not contained in the compliance aid/ chemipack	Supervised stage 1 medication administration requires increased vigilance.	Closed
GHC79233	13/11/2024	13/11/2024	08:00	North Cotswolds Hospital & GMC	NC Hosp-Cotswold View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Pharmacy	Methotrexate	No					Patient transferred with medications dispensed from GRH pharmacy. Box labelled 'Methotrexate 2.5mg tablets, take TEN tablets once a week on Wednesdays'. Inside box there are 4 unused strips of 10mg tablets, so 40 10mg tablets.	SN identified dispensing error prior to administration. have sourced methotrexate 2.5mg tablets from Fairview pharmacy. 10mg tablets in incorrect box, to be disposed of.	As soon as the error was identified the medication was removed to ensure it was not administered. The patient was administered the correct dose of the medication. Discussed with ward pharmacist who advised the medication be destroyed and correct medication was ordered. The pharmacy at the acute trust were also notified of the error.	The importance of ensuring that medication foils inside boxes of medication are checked prior to administration.	Closed
GHC79267	13/11/2024	13/11/2024	14:00	ICT	ICT Stroud Cotswolds DN	GP	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Monitoring / follow-up of medicine use	Insulin human	No					Working in referral centre - received message from diabetic nurse specialist to advise we were giving the wrong dose of insulin. She had decreased patient's Lantus dose and added in new insulin - 4 (four) units of Humulin I insulin, and asked GP to prescribe this on yellow drug charts. DNs visit 1x daily to check BGL and administer insulin. charts collected from surgery and new regime was started on 06/11/24. DNs have been administering 14 units (fourteen) of humulin I daily.	Checked with staff who had visited patient recently - they confirmed that the drug chart states to give 14 units of Humulin I. Arranged for new drug chart to be written by GP for 4 units. Arranged for DNs to collect tomorrow and start this tomorrow at next visit. Also asked that DN brings old drug chart out of home and puts it in our locked box in the office so we can confirm that the prescribed amount on the drug chart was wrong. Called diabetic nurse specialist - she confirmed no harm has come to patient, BGL are lower but not worrying low, the patient may need more than 4 units of Humulin I but this is to be titritrated slowly. Advised we will get new drug chart, she will send request for 4 units to GP surgery again. She asked us to gather some data from patients libra sensor over next couple of weeks and send it to her.	14/11/24- drug chart now obtained and added to Datix. Drug chart clearly written up for 14 units of Humulin I. Confirmed no harm to patient, insulin dose has been reviewed and new chart written up and previous drug chart removed from property to add to notes.	Miscommunication between Diabetic Specialist Nurse and GP.	Closed
GHC79297	14/11/2024	13/11/2024	08:45	ICT	ICT Glos North South DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Prescribing	Insulin glargine	Yes	12 units		Subcutaneous		Visited to administer insulin- noted that medication chart had not been signed by prescriber. Insulin had been being administered	Chart removed from home and new chart in its place. Band 6 informed. Datix.	Staff had been administering insulin from a drug chart that did not have a GP signature. S1 checked - dose/administration time/frequency was correct. Patient had the medication intended. No harm caused.	Email sent to all staff who had visited to inform them of their error, reminded them of the 6 R's of medication administation and requested reflection + book onto 6 steps of insulin safety E-learning.	Closed
GHC79301	14/11/2024	13/11/2024	09:00	ICT	ICT Glos North South DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Prescribing	Insulin glargine	Yes	16 units		Subcutaneous		Visited home to administer insulin- noted that chart in use had not been signed by prescriber.	Chart removed from home. Band 6 for team informed. Datix.	Staff had been administering insulin from a drug chart that did not have a GP signature. S1 checked - dose/administration time/frequency was correct. Patient had the medication intended. No harm caused.	Email sent to all staff who had visited to inform them of their error, reminded them of the 6 R's of medication administation and requested reflection + book onto 6 steps of insulin safety E-learning.	Closed
GHC79306	14/11/2024	11/11/2024	22:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Prescribing	Pregabalin	Yes	200		Oral		During medication administration for 22:00hrs Pregabalin was stopped. Patient had a dossett box and I informed her the reason why I am popping her medication. She said no-one told her that her Pregabalin was going to be stopped. I reassured her that I was going to call the Duty Dr and clarify the issue.	I read through the Doctors entry and Pregabalin was meant to be stopped on Friday morning prior to PET Scan. I informed the Duty doctor who said it was re-prescribed but wasn't confirmed and he confirmed it and I was able to administer it.	Consultant has discussed with resident medic	No further lessons identified	Closed
GHC79315	14/11/2024	11/11/2024	09:00	ICT	ICT Glos North South DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Insulin human	Yes	74units	74units	Subcutaneous	Subcutaneous	Planned visit for insulin administration for patient with DMT2. Patient is on Abasaglar and Trurapi. On insulin chart Abasaglar were given at 12pm the previous day. Insulin administered at 8.40 which was 3.5hrs before 24hrs. BGL at the time 16.5mmol/L	none	Nurse has documented that no action was taken at the time of the incident and she gave the insulin.	The visiting nurse should always check the documentation on system 1 prior to visiting the patient, and check the timings of previous administration and adjust the visit according to correct times.	Closed
GHC79350	14/11/2024	14/11/2024	18:30	MIIUs	MIIU- Ciren Hosp	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Medication breakages / spoilage	Storage	Morphine	No					Oral morphine dispensed as per prescription during shift, stored in Controlled drugs cupboard after dispensing, stored on horizontal side. Cap not fully closed when stored. when opening cupboard at 18:30 notes oral morphine has leaked inside cupboard+, spillage witnessed by S ENP and staff nurse.	Remaining amount of oral morphine recalculated as 16mls using syringe, spill cleaned using clinell wipes,	No further action required, spillage was recorded appropriately	No further action required, spillage was recorded appropriately	Closed
GHC79373	15/11/2024	13/11/2024	13:30	ICT	Reablement Stroud	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong time / frequency	Use / possession of over-the-counter (OTC) medicine	Mirtazapine	No					Home First Team informed in MDT meeting that Psychiatrist had found that patient was using an dosette box dated 18th Oct - this was week beginning 11/11/24. Senior Reablement Worker for Home First explained at the meeting that at first visit , patient was able to discuss her medication correctly and wished to self medicate. Therefore the Home First staff were not assisting with medication. The Reablement workers were doing a verbal check and patient was always stating she had taken her medication.	During the meeting Senior Reablement Worker raised her concern that the patient may have other medication hidden in the home and that this would increase the risk if Home First staff assisting with medication. The 2 close friends present at a the meeting, agreed to visit the patient later the same day and gain permission to check the home for old medication and remove it. The plan was for the friend to update the Senior Reablement Worker and then she will visit again to reassess for support with medication using the risk assessment. It was discussed that one option is using a locked box which the patient would have to agree to and purchase.	Discussed with reported - Medication concerns were raised by psychiatrist during MDT - who I been informed has raised concerns with the GP. Service user was taking medication from the wrong date of dossette box. Team were not involved with medication but were checking verbally if patient had taken it SRW has reviewed and ensured correct medication in property and further assessment of ongoing needs.	No harm to patient However service needs further development around the identification of prompting medication the team were checking if Service user had taken medication then there is responsibility on the team to ensure medication is correct and date. This would need to be recorded on a MARS sheet	Closed
GHC79389	15/11/2024	12/11/2024	17:00	Medical	Medical - Education	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Drug chart errors - not signed, recording, other	Prescribing	Lorazepam	Yes	mg		Intramuscular	Intramuscular	Unclear RT prescription and administration. Dr on ward - staff asked if they could administer IM lorazepam to agitated patient (new admission) as RT. RiO notes state verbal consent given. Dr was on ward but RT IM lorazepam was not prescribed, no documentation in RiO that this consent was given (RiO note made by Dr during clerking clearly states patient may benefit from oral lorazepam) Staff that administered IM lorazepam probably made 2 notes on RiO using the temporary access card (not signed by staff so I have no idea who it was). One stated 1mg IM and the other stated 2mg IM given. Although RT was not available on the ePMA chart, IM lorazepam was prescribed as PRN but this was not signed as administered, so I cannot confirm the dose (although the intervention was DATIX reported.	I found the incident out by chance as part of the med rec process the following day Contacted Dr [named removed] re medic training and ward manager re use of TAC card	Dr involved unfamiliar with Trust procedures and EPMA Teaching delivered, no further incidents	Staff using EPMA require induction/training prior to working on the wards	Closed
GHC79394	15/11/2024	15/11/2024	12:45	CYPS/PH Public Health Nursing	CYPS/PH- Health Visiting	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong / unclear dose or strength	Administration	Chlorphenamine	Yes	15ml	2.5ml	Oral		Miscommunication of drug dosage. Patient observed in home address with Mother. Patient observed to have a significant allergic reaction on legs/torso. Mother of patient, stated that the patient had a dose of Chlorphenamine Maleate (unspecified by Mother) at 0800am. Health Visitor and Student Health Visitor ascertained that the suitable time had elapsed between the dosages and what was recommended on the bottle (4 to 6 hourly) At 1245pm on the 15th November 2024 a second dose of Chlorphenamine Maleate was administered by Mother.	HV and Student HV had already stated for Mum + Patient to attend local Minor Injuries unit prior to the realisation of medication error. This was due to the ongoing allergic reaction. HV and Student HV both supported Mum in actively getting ready to leave the property. HV after reflective discussion with Student HV, re-attended the home address to discuss concern over overdose. HV informed Mum of error, and explained that attending the MIU was now of utmost importance. Patient observed to be content, settled and engaging upon HV leaving the address. No obvious signs of distress were observed, such as breathing,	Very confusing account given of timeline however clarified points with HV. At no point did HV advise on a dosage apart from saying that they can have another instructed dose as enough time had elapsed since the last dose. Staff were not involved in the giving of the medication at any point, only measured and administered by parents. HV gave suitable advice regarding seeking medical attention.	HV could have asked parent what dosage they gave in the morning. Advised HV that any prescribing advice, even if not writing a prescription is considered prescribing practice and should not be done without ascertaining a full history and ensuring own prescribing practice is current.	Closed
GHC79402	15/11/2024	28/08/2024	09:00	Recovery	Recovery Stroud	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Flupentixol	Yes	50 mg		Intramuscular		Depot given 5 times with unsigned prescription	datix raised			Awaiting Review
GHC79421	15/11/2024	15/11/2024	12:00	ICT	ICT Forest South DN	GP	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug has expired	Pharmacy	Midazolam	No					Routine visit for Syringe driver Medication checked and had been dispensed on the 10/10/24 but the medication had expired 08/2024	Surgery/dispensary where medications came from contacted and updated. medications removed and crossed out. New in date medications requested	22/11/2024 - Community Nursing Lead - Incident & notes reviewed - Out of date medication dispensed for patient - Not identified at initial stock check by DN's. - Surgery made aware of error in dispensing and new meds dispensed - No delay in treatment as patient not using this medication at that time.	Thank you for your report. - Appropriate actions taken on identification of expiry date. - Reminder to staff at team time the importance of checking dates when stock checking meds. - Surgery to follow up in house regarding dispensing.	Closed
GHC79441	16/11/2024	15/11/2024	22:50	Wotton Lawn Hospital	Wotton Lawn-Abbey Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Contra-indication in relation to drugs or conditions	Administration	Paracetamol	Yes	1g	1g	Oral	Oral	Sn advised not to give medications due to patient taken medication and cannabis and alcohol off ward however medication administered.	Duty doctor informed, physical observations taken and observation level increased to 15/15			Being Reviewed
										Contra-indication in relation to drugs or conditions	Administration	Pregabalin	Yes	50mg	50mg	Oral	Oral					
										Contra-indication in relation to drugs or conditions	Administration	Quetiapine	Yes	50mg	50mg	Oral	Oral					
GHC79481	17/11/2024	16/11/2024	22:05	Wotton Lawn Hospital	Wotton Lawn-Kingsholm Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Haloperidol	Yes	5mg		Oral		One of the patient became acutely agitated at 10pm - he asked for ward phone , but this request was then declined as he already made a call during the late shift, he then pushed himself into the nursing office and tried to assault 2 staff, and then opened the fridge and starting trying to throw things from it. PMVA call was put out. He was given oral promethazine 50mg PRN during late shift about 18:00 hours, still not settling. Called for PMVA for physical aggression ,and offered haloperidol (RT) 5mg orally at 22:05 hours as it was prescribed as PRN, and it was given yesterday at13:44 hours, more than 24 hours At the time of signing in electronic medicine chart , it was not allowed to sign ,should be reviewed by the medics. RT was administered without it being prescribed at that time due to urgency. It was administered daily as PRN ,order was there in the RT section T	- Called the duty doctor immediately after administered haloperidol 5mg orally and notified the issue with signing the medication in the system. - Physical observation done once as he agreed at 22:30 hours, then maintain non- contact physical observation chart hourly - discussed with duty doctor and stat dose was prescribed and signed in the system.	Staff member (non-regular ward staff) had been on shift, faced with a difficult situation with challenging patient that had entered Nursing office and sought to assault nursing staff. Staff member raised alarm and a PMVA team attended, patient was offered haloperidol, however the dose given to patient was not at the time prescribed by a medic. The nurse had noted that RT haloperidol had been given previously as the medication was showing on EPMA system, however at the time of administration the dose given had not been prescribed. Staff member alerted medic on call whom and reported they were unable to sign for the dose given as the dose had yet to be reviewed and deprescribed. Upon further investigation the medic established that the dose given did not breach maximum dose within timeframe, observations within usual parameters, and patient remained alert and active upon the ward. Medic reviewed this incident with on-call SPR, whom advised to ensure documentation was clearly recorded and noted as the time the dose was	Staff member completed self reflection in which she acknowledged the need for prescription, even in emergency situation, before administering medications. Staff member ceased completing medication rounds until this matter had been thoroughly investigated and resolved. Staff member completed duty of candour with the affected patient.	Closed
GHC79500	17/11/2024	17/11/2024	11:06	ICT	ICT Chelt Town Centre DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Hydroxocobalamin	Yes	1mg/ml	1mg/ml	Intramuscular	Intramuscular	- Visited patient for loading dose of B12 Injection. - Carer brought the MAR chart and B12 ampoules into patients room. - MAR chart states there should be 3 ampoules remaining as of 14/11/2024 visit. The box of Hydroxocobalamin that carer gave me only has 2 ampoules in it. - Checked with Home Manager about the B12 ampoules and she said they don't have any other boxes for patients B12, they only have the one box which carer gave me. I explained our stock sheet states there should be 3 ampoules left but there were only 2 in the box. Manager checked the homes MAR sheet and said they only had 3 ampoules originally delivered. - I explained to manager our MAR chart states 6 ampoules were stock checked in on 7/11/2024. - Manager said she isn't sure what's happened and said there is definitely only 1 box. Manager said she will contact the pharmacy tomorrow to chase if there is anymore ampoules at the pharmacy waiting to be delivered.	B12 Injection administered as prescribed. Datix completed as 1 missing ampoule. Home manager contacting Pharmacy tomorrow to chase if anymore ampoules at pharmacy to be delivered.	Carers unable to find hydroxocobalamin ampoules temporarily - unsure where they were but turned up for remainder of doses required - ? if were owed at pharmacy and then delivered at a later date.	N/A - all appropriate actions taken.	Closed
GHC79573	18/11/2024	11/11/2024	09:20	ICT	ICT Glos North South DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Pharmacy	Other (unlisted)	No					No medication dosette boxes in the home I telephoned the Pharmacy to chase up medication dosette boxes to be told they had been delivered by the driver on the previous Friday I explained there were none in the home Pharmacy staff checked and informed me they had not been delivered due to waiting for insulin pens to arrive Advised that the patient is due medication this morning which nurses visiting prompt as medication is in a locked box which patient does not have access to I was informed the driver would not be able to deliver until later that day as he was not due in until late morning. Advised that this was not acceptable and and the medication would need to be in the patient's home prior to my visit this morning Pharmacy staff member arranged with colleague to deliver medication straight away following my call.	Pharmacy delivered medication dosette boxes as arranged Documented incident in patient notes on S1 Reported to DN PST team aware of incidences with this pharmacy - as advised, I will redirect the datix to them. I am awaiting to hear back from pharmacy with the outcome of their independent review into these incidents.	I have spoke to the pharmacy about this incident, I am awaiting to hear back from pharmacy with the outcome of their independent review into these incidents. PST aware of the incident.	Please continue to datix any concerns re: medication administration and delivery.	Closed
GHC79576	18/11/2024	17/11/2024	10:00	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Insulin glargine	Yes	16 units		Subcutaneous		Paperwork not completed but Insulin given	Rang the nurse who visited who confirmed she gave Insulin but forgot to do the paperwork	No harm - patient received medication - drug chart not signed Asked line manager to discuss at next 1 to 1	Good use of datix - no harm to patient - Human error made	Closed
GHC79634	19/11/2024	19/11/2024	10:30	Wotton Lawn Hospital	Wotton Lawn-Kingsholm Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong formulation	Administration	Paracetamol + Codeine + Buclizine	Yes	30/500	15/500	Oral	Oral	Service user was prescribed Cap Cocodamol (Codeine 15 mg and Paracetamol 500 mg). Staff administered Cap Cocodamol (Codeine 30 mg and paracetamol 500 mg) instead	Duty of candour to be completed when service user back from unescorted leave. Discussed with Medical team who has adviced for his next dose to be omitted . Communicated with team to not administer next dose. Reflective account requested from staff	Further investigation into this medication incident - the error was identified when staff member approached band 6 nurse to report no stock of correct medication. Band 6 nurse was aware that medication had been obtained on previous day, and as such stock should remain in clinic. Upon further investigation it was discovered that one tablet of incorrect dose had been missing, leading to conclusion that incorrect dose had been administered to patient. Cross checks made with staff member whom recalled having given a dose from strip with 1x tablet missing, as such confirming the incorrect dose had been administered. Medication error procedure instigated, staff member concerned was requested to provide a written reflective piece regarding the error, the steps taken and procedure for correct administration of medications.	* Staff member identified and information shared with staff member regarding the error. * Once confirmed the staff member was requested to provide written account of the incident. * Learning shared with staff member around the correct and safe procedure for administration of medication.	Closed
GHC79658	20/11/2024	19/11/2024	09:00	ICT	Reablement Gloucester	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Amlodipine	Yes	3x 5mg tablet	1x 5mg tablet	Oral	Oral	Reablement worker alerted Senior Reablement worker that Patient had taken medication from 2 morning pockets from the dosette. Patient could not say when this had happened.	Reablement worker prompted Patient to take medication from correct pocket. GP contacted by Senior Reablement worker who reviewed unintentional Overdose and advised that no further intervention required.	All correct actions taken at time of incident - to continue to monitor patient and medication	As above	Closed
										Wrong time / frequency	Administration	Colecalciferol	Yes	6x 25mcg tablets	2x mcg tablets	Oral	Oral					
										Wrong time / frequency	Administration	Donepezil	Yes	3x 10mg tablets	1x 10mg tablet	Oral	Oral					
										Wrong time / frequency	Administration	Folic acid	Yes	3x 5mg tablets	1x 5mg tablet	Oral	Oral					
										Wrong time / frequency	Administration	Thiamine	Yes	3x 100mg tablets	1 100mg tablet	Oral	Oral					
GHC79662	20/11/2024	17/11/2024	20:00	ICT	Reablement Stroud	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Baclofen	Yes	10mg	5mg	Oral		Required to split Baclofen tablet to give her 3 halves a day, she was given 4 halves on 17th & 18th Nov. Reported to RCO and family when error discovered (19th Nov). GP has not been informed, family not concerned as no visible affect on patient.	Correct dosage has been given from 19th November	No further action	Team acted according to rectory situation Further development from learning team being looked at with GRH	Closed
GHC79672	20/11/2024	19/11/2024	08:30	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Other (unlisted)	No					Took a long time to administer his insulin. Attached needles to pen as always, and when I went to prime no insulin coming through. Tried to reposition needles, tried different types of needles and none would work. This is a cartridge pen so removed cartridge many times and replaced, tried to put in a new cartridge- still wouldnt prime. I then realised that the spring that is usually in place was down and not in place, i unscrewed the spring so it came up further and put it in place on the cartridge and it then primed and gave insulin	see above	- Patient received medication. - Issue trouble shooted at time of incident without affecting patient care.	- Remind everyone in team time of importance of priming insulin pens in order to identify this sort of issue.	Closed
GHC79687	20/11/2024	20/11/2024	11:15	Wotton Lawn Hospital	Wotton Lawn-Abbey Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Prescribing	Nicotine	Yes	21mg nicotine patch and inhalator		Inhalation		Patient review as a part of a harm reduction/ quit attempt and a 4-hour delay in administering Nicotine replacement resulted from increased anxiety and withdrawal.	TTDA assessed the patient and agreed on a treatment plan for the Patient. The patient asked if this could start right away. TTDA approached the nurse in charge of medication for the AM shift and asked for this to be given. However, the NRT medication failed to be administered even after a formal ward drug was around.	none	none	Closed
GHC79706	20/11/2024	20/11/2024	11:00	Charlton Lane Hospital	Charlton Lane-Chestnut Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Monitoring / follow-up of medicine use	Madopar (co-beneldopa, levodopa benserazide)	No					Patient went for overnight leave with all her TTOs. Husband reported to late staff that he forgot to give her 11:00 SINEMET 187.5MG tablet. He said they were both pre-occupied with having her hair done and forgot about it.	When I was handed over by late shift staff ,I spoke with her and she confirmed that they forgot about it. I checked her TTOS and saw that 3 doses were taken instead of 4 and informed Duty Dr who said I should give the night dose and she will be reviewed by day team tomorrow.	patient returned to the ward and was monitored- no adverse effects noted from missing dose	NA	Closed
GHC79730	21/11/2024	21/11/2024	11:28	Wotton Lawn Hospital	Wotton Lawn-Abbey Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Oxybutynin	Yes	20mg	20mg	Oral	Oral	When checking the morning medication round, staff nurse became aware that they administered a patients medication at 0830 instead of 1200. Medication is used to treat an overactive bladder. Patient appears to be fine.	Discussed with medical and pharmacy team - no concerns Medication error protocol initiated	none	none	Closed
GHC79758	21/11/2024	21/11/2024	08:45	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Insulin isophane human	Yes	unknown	20units	Subcutaneous	Intramuscular	I primed up the insulin pens for the patient for her to administer under supervision. When she administered the Humulin I pen, afterwards there was a lot of fluid in the safety needle. I am unsure how much she administered of the 20Units of Humulin I.	Care staff and lead RN informed.	Incident involves safety needles this brand has been renowned for having insulin residue in chamber. Unclear if full amount of insulin administered. Discussed at teamtime and advised to change needle brand to micro dot needles. These are easier for the patient but also does not appear to be any residue of insulin. Training sessions arranged for safety needles.	Unclear if user error or whether it is the normal residue of insulin that is found in the safety needles. No adverse effects to patient. Needles to be changed to micro dot safety needles as these do not seem to leave insulin residue.	Closed
										Drug chart errors - not signed, recording, other	Administration	Simvastatin	No									

Drug chart errors - not signed, recording, other	Administration	Apixaban	No				
Drug chart errors - not signed, recording, other	Administration	Cyproterone	No				
Drug chart errors - not signed, recording, other	Administration	Gabapentin	No				
Drug chart errors - not signed, recording, other	Administration	Memantine	No				
Drug chart errors - not signed, recording, other	Administration	Paracetamol	No				

GHC79795	22/11/2024	21/11/2024	22:00	Charlton Lane Hospital	Charlton Lane- Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Paracetamol	No					The Agency Nurse did not electronically sign for 16 medications during the 20:00 medication round, despite being told of how the charts indicate what should be given at what time. This was reported by the Nurse in Charge/Medication Nurse for the following night shift.	Datix to be completed, Ward manager notified. Clinical Support Manager - Temporary Staffing notified.	Agency informed following missed dose audit	NA	Closed
										Drug chart errors - not signed, recording, other	Administration	Cyproterone	No									
										Drug chart errors - not signed, recording, other	Administration	Apixaban	No									
										Drug chart errors - not signed, recording, other	Administration	Melatonin	No									
										Drug chart errors - not signed, recording, other	Administration	Mirtazapine	No									

										Drug chart errors - not signed, recording, other	Administration	Paracetamol	No									
										Drug chart errors - not signed, recording, other	Administration	Senna	No									
										Drug chart errors - not signed, recording, other	Administration	Ibuprofen	No									
										Drug chart errors - not signed, recording, other	Administration	Olanzapine	No									
GHC79826	22/11/2024	22/11/2024	10:30	Psychiatric Liaison	MH Liaison Alcohol Inpatients	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Drug administration omitted / delayed	Administration	Diazepam	No					A patient was admitted with a PMH including prior alcohol withdrawal seizures. It was also documented, on ED triage/assessment & clerking documents that she has been drinking at least 500mls of spirits up to the point of admission. CIWA was prescribed to assess/treat alcohol withdrawal symptoms. Unfortunately the patient was only assessed once so only received 1x7mg diazepam. The patient, approx. 8 hours later had a likely alcohol withdrawal seizure. If the patient had been assessed every 1-2 hours, via CIWA, then they would, in all probability, not experienced a seizure.	ALT discussion with the patient followed by ALT discussion with the Doctor & Nurse looking after the patient. Doctor - Agreed a plan to re-prescribe the initial 24 hours of CIWA assessing/treatment. Nurse - Agreed that CIWA assessing should take place every 1-2 hours for the next 24 hours (to ascertain if a detox regime is clinically indicated). ALT to review.	PLease see datix progress note for GHFT outcome and action.	Disseminated by GHFT	Closed
GHC79835	22/11/2024	22/11/2024	13:30	Recovery	Recovery Gloucester	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Ordering, collection or delivery	Quetiapine	No					Medication checked in Pharmacy Store Room, Pullman Place with colleague: - Box had 92x200 mg Quetiapine tablets instead of 112; box returned to GRH Pharmacy - they supplied the missing 20 tablets; I then took medications to patient.	Acting Manager notified his Manager. Pharmacy notified - they said they would do Datix about missing 20 x 200 mg Quetiapine tablets. They then supplied missing 20 tablets which were delivered to patient.	Previous dispensing issues with this patient noted, agreed plan with pharmacy has been since for CC to attend pharmacy and check with pharmacist all medications dispensed before taking to patient. On review, reporter (CC) unclear why on this occasion medications had been delivered but agreed to highlight and ensure continuation of previous arrangement. Reminder given by handler RE need to transfer medications which are stable to GP, acknowledging the challenges in this as patient who has ASC dislikes change but the importance given her own history of miscounting/managing and the additional physical health (constipation related) medications prescribed by Recovery which is outside community remit as non-psychiatric.	Reminder of keeping to previously agreed plan for individual patient going forwards. No wider learning. Issue of less medications in pack flagged to pharmacy no clear understanding or likely to be known for cause of this.	Closed
GHC79853	23/11/2024	23/11/2024	09:30	ICT	ICT Cotswold South 2 DN	GP	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong route	Prescribing	Betamethasone + Fusidic acid	No					Delay in commencing topical steroid treatment because there was inadequate information on the dispensing label: Betamethasone valerate 0.1% / Fusidic acid 2% cream30 gram - apply twice daily, a single course should not last longer than 2 weeks usually	Issue initially noted 22/11/24 - RN attended surgery for clarification Discussed with admin staff Admin staff discussed with GP and rang patient 22/11/24 No supporting documentation on S1 to indicate location of applicaiton of topical treatment Agreed cannot commence treatment until confirmed with GP Email sent to surgery to outline MAR chart requirements and information needed DN will also discuss at weekly GP meeting and ensure information needed documented on S1 to enable MAR chart to be completed and commence treatment	documented in patient records that steroid cream was prescribed awaiting to be applied on the 19th November. Request resent on the 20th November for steroid cream. 22nd November RN attended noted lack of information on treatment prescription therefore not able to apply cream	Good observation of checking prescription Communication followed up with GP to ensure for prevention Lack of clarity with information on care plan or treatment/management plan on patient notes therefore risk community staff may not be aware that cream is required	Closed
GHC79858	23/11/2024	23/11/2024	10:30	Wotton Lawn Hospital	Wotton Lawn-Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Disposal	Sodium valproate	No					7 tablets in a paper cut were handed to staff from the Domestic assistant which were left in the sluice .	Tablets were taken given to staff to put in the clinic blue bin .	policy and procedure followed	patient palming medication nurses to be more vigilant	Closed
GHC79864	23/11/2024	23/11/2024	08:50	ICT	ICT Stroud BerkeleyVale DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Administration	Insulin human	Yes	14 units	14 units	Subcutaneous	Subcutaneous	I visited the patient this morning for insulin support - pt has BD insulin. I took out both pens from the box and checked prescription charts to ensure correct drug/dose. Placed both pens on the worktop with paperwork. Checked batch number and expiry date and dose for Humulin insulin that was due this morning, documented on paperwork, ready to sign at the end of procedure. Checked BGL via libre sensor, documented and then returned to paperwork. Plugged in sensor to charge. Carer asked me if he could leave key with me as he was leaving soon - I agreed and he left the key. Picked up pen, attached needle, primed and dialled up insulin 14 units as per prescription. Went to patient and checked all ok, administered insulin and then returned and placed pen back on the side. Carer informed me he was leaving at this point. Returned to paperwork to sign document and put insulin & documentation away. Afterwards, I questioned which insulin pen I had administered as I had put them down together.	Normal procedure - patient appeared well, carried out normal procedure for insulin administration. It was after the visit that I questioned whether I had picked up the correct pen. Note from previous days visit stated that they were unsure if the carers had visited and pt had informed them he had not had much to eat yesterday. His BGL was 8.2mmols so I had asked him if he wanted me to get him anything before leaving - he asked for a piece of toast with butter so I made this for him to ensure he had had something to eat. He stated he had sweet treats to take if he felt he needed them. Pt lives with grandson.	Thank you for completing this datix You acted accordingly, by informing the Band 6 on shift The OOH GP was informed Blood were taken by rapid response No harm was caused to the patient	You have completed a reflection on what has happened E- learning completed - administration of medicines and insulin safety update and theory, and the six steps to insulin safety Clinical supervision with Band 7 I have also discussed with the Patients band 6 into whether we can separate the morning and evening pens and charts into folders to prevent this from happening again	Closed
GHC79906	24/11/2024	23/11/2024	16:00	North Cotswolds Hospital & GMC	NC Hosp-Cotswold View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug administered when stopped	Administration	Buprenorphine	Yes	5mcg	5mcg	Not applicable	Not applicable	Patient has been prescribed buprenorphine patches 10mcg which was reduced due to increased drowsiness. The dose was reduced to 5mcg on 12/11/24 and the patch was stopped on 18/11/24. The patient was then re-started on butrans patches 5mcg on 22/11/24. This patch was documented as being placed on the right side of the chest. During the routine weekly skin check an additional patch was found on the upper right arm.	The location of the newest patch was found in the notes and the patch on the upper right arm was removed.	Appears to have been communication breakdown. Patch stopped by medics on 18/11/24, but nursing staff not informed to remove current patch on patient. Picked up on routine skin check and when patch was restarted 4 days later. No harm, or ill effects noted by patient.	Reminder to be given to all staff to ensure reading DR's notes throughout shift. Reminder given to medics to verbally inform nursing staff when medications being stopped, especially when this involves removing a patch.	Closed
GHC79932	25/11/2024	24/11/2024	22:28	Wotton Lawn Hospital	Wotton Lawn-Abbey Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong route	Administration	Lorazepam	Yes	STELLA MWANGI		Intramuscular	Oral	While staff doing the 22:00 checks, patient was observed as head banging against the wall by sat down on floor. Staff went there to verbally de-escalate and attempted to use the de-escalation techniques but appeared as she was unable to engage with staff at that moment. Observed as struggling more and was not able to de-escalate verbally. Tried various things patient like as ice pack and smelling the tiger bam. To prevent her injuring herself more in line with her best interest staff made a team decision to call a planned PMVA to give her some medications. Called a planned PMVA with only female staff, and given RT Lorazepam 1 mg but was prescribed as oral.	Reflected and informed the doctor. Changed the prescription.	Line manager of nurse involved informed of med error Highlighted with RT trainer this has happened several times and may need introducing into training	none	Closed
GHC79942	25/11/2024	23/11/2024	08:30	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Prescribing	Lorazepam	Yes	0.5mg	0.5mg	Oral	Oral	Called the Duty Dr to request PRN Lorazepam to be prescribed for a patient who was presenting with agitation and restlessness, refusing personal care despite being incontinent. Duty Dr agreed to prescribe, called back 10 mins later to inform it had been completed, however RT had been prescribed rather than PRN. Asked if this could be changed to PRN or stat dose, however Duty Dr thought they had already done this. Explained that they had actually prescribed RT. Duty Dr said they will sort and did eventually prescribe PRN Lorazepam.	Corrections made to prescription. PRN Lorazepam administered to patient with good effect.	Appropriate action taken by nurse at time of incident	All medics need to have training and ensure competency on RiO prior to duty to ensure that prescribing errors are mitigated and treatment for patients is not delayed.	Closed
GHC79954	25/11/2024	25/11/2024	07:00	ICT	Reablement Cheltenham	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Controlled stationary (medication related)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Paracetamol	No					Rw rang SRW advising that patient has no medication for the morning to take as dorsette box was finished last night and no further medication delivered.	RW contacted SRW to inform that no medication present to assist.	discussed incident with patients relative who raised the incident - and worker involved -patient was checked out by A and E no significant harm identified - reviewed records and discussed with training and learning team re medication refresher training that has since been developed and is being delivered to all HF/ R staff countywide	incident reflected on in 1-1 with staff member involved and further learning shared with training and learning department re medication errors meds refresher training attended	Closed
GHC79955	25/11/2024	25/11/2024	08:30	ICT	ICT Glos HQR DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Pharmacy	Insulin glargine	No					Visit for insulin administration. 1 unit left in pen and no more insulin in the property.	Urgent order had already been placed 1 week prior. Pharmacy notified that delivery had not be received. They assure me insulin will be delivered asap and return visit will be needed to administer. Patient is well and about to have breakfast.	Thank you for reporting this Datix. I can see that the Insulin was ordered in good time. This was a pharmacy delay and out of our control. Thank you for sorting this out, the patient did receive their Insulin late on this day but should not have caused any harm.	No future learning identified.	Closed

GHC79988	25/11/2024	25/11/2024	10:00	Cirencester & Fairfrd Hospital	Ciren Hosp- Coln Ward	Pharmacy-community	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Supply issue	Pharmacy	Other (unlisted)	No					there is a delay in the delivery of Octenasin md nasal gel which is prescribed post MRSA treatment for those who are mupirocin resistant the drug was prescribed at the weekend and requested, pharmacy are awaiting a delivery themselves and this will be delivered to us 26th nov pm so this will a delay in treatment	IP(C team on site and aware , both patients who are prescribed this are on shower wash already but will need to start their full 5 days of treatmnent when the nasal cream arrives	IP&C are aware that there is a supply issue. Drug is not a stock item and it has been suggested that perhaps it should be added to the stock list to try and prevent this occurrence happening again. Patient is having the body wash therefore has commenced her treatment but the nasal ointment is delayed	None - all actions taken were proportionate and correct	Closed
GHC79991	25/11/2024	22/11/2024	09:30	ICT	ICT Stroud Referral Centre	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Atorvastatin	No					Patient took all of medication for one day from the dossett box and took it all at once in the morning	GP was phoned by the family member who was at the address at the time GP rang family back to say that taking a days medication all at once would not have any adverse effects on the patient, she would be ok.	Action ed accordingly by staff	None	Closed
GHC80023	26/11/2024	26/11/2024	10:50	ICT	ICT Stroud BerkeleyVale DN	Pharmacy-community	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Ordering, collection or delivery	Paracetamol	No					Visited patient for medication administration. New bag from pharmacy had been arrived unpacked medication into locked box and noted box of paracetamol which had been prescribed for another patient in with this patients medication	Rang pharmacy to inform them, they will arrange collection today. Put medication back into bag and wrote on it for collection, patient informed medication not for him	Thank you for taking the time to datix this incident You contacted Glos pharmacy who then collected the medication No harm caused to the patient Patient advises medication has been removed from the house	None at this time	Closed
GHC80075	27/11/2024	20/11/2024	13:00	Recovery	Recovery Gloucester	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Diazepam	No					During routine audit of pharmacy store, noted ten 2mg diazepam tablets were missing.	Double checked against signing in and out record, and medication disposal form. Checked against patient Rio record Emailed Care co-ordinator to clarification. Updated service lead, acting team manager, clinical lead and nurse lead. Emailed whole team for any information. Discussions with nurse lead regarding implementing new signing in and out forms earlier than planned.	Liaised with Lead nurse and met jointly with CC after return from placement to discuss as some issues in regards to medications which belonged to patient and the dispensing of these were highlighted. Patient had got new prescription so medication was not needed but CC had forgotten to ask qualified nurse to support and then went on placement hence it being left in cupboard.	Reminder of SOP with guidance on destroying medications, how to do this and importance of recording both in pharmacy room and on RIO shared with relevant clinicians in team. Reminder given RE medications not prescribed by patient not to be 'issued' or 'kept' by Recovery team clinician but either destroyed if significant overdose noted as in this case and then advice given to GP RE prescribing quantity being changed and need to re-prescribe or short term prescription to be issued ahead of GP alert, update and request of need to issue with same restriction guidance due to risk.	Closed
GHC80097	27/11/2024	27/11/2024	11:00	Tewkesbury Hospital	Tewk Hosp- Abbey View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Methotrexate	Yes	2.5 mg	25 mg	Oral	Oral	Patient was prescribed Methotrexate 2.5 mg, 10 tablets to be administered on 26/11/24 at 8:00 am every week. only 1 tablet administered instead of 10 by mistake.	-whilst having discussions with the pharmacist on 27/11, I realised that i have only administered 1 tablet. - i informed the doctor on duty straightaway about the error who prescribed "Once only" dose of the rest of the 9 tablets to be administered on 28/11 @ 8 am. - I went to see the patient and explained about this error and apologised and explained that the rest of the tablets will now be administered tomorrow. - Patient was not worried about this as she explained that her consultant said that if she ever misses the dose, she can have it the next day- not on the same day as folic acid.	The ward was very busy and the other trained nurse that was on with them had to leave the ward. for a short time this left one trained nurse looking after the ward and trying to do the drug round and organising the ward. Written Reflection completed by nurse involved., Nurse involved is fully aware of what went wrong and why and has reflected on this and has looked at some learning points and learning need. Duty of candour adhered to patient informed and apology given. Datix completed Dr informed straight away.	Thank you for completing the datix and reflecting on the incident. When the ward gets too busy again they have reflected on the best way to handle the situation and will delegate effectively. Minimise distractions by communicating to the team the importance of the drug round and not to get distracted.	Closed
GHC80156	28/11/2024	28/11/2024	08:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Paracetamol	Yes	1g		Oral		Patient has been prescribed paracetamol tablets as regular medication 1g four times a day. However, the patient has asked for another dose of paracetamol at 02:00 hours therefore, the night staff has given 1g paracetamol as discretionary medication. Patient resulted in having 5g of paracetamol in 24 hours.	Informed the ward Doctors Completed a set of physical observations Patient's morning paracetamol was omitted.	Incident managed appropriately by nursing team Nurse has completed reflection	No further lessons identified	Closed
GHC80199	29/11/2024	14/11/2024	19:00	Stroud Hospital	Stroud Hosp- Cashes Green Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Warfarin	Yes	Warfarin		Oral	Oral	Warfarin administered. I had read the prescription, however misread the date and thought it was due to 14/11/24. I had administered medication although it had not been prescribed.	When i realised this medication error, I went straight to the patient to apologise for the incident. I informed that patient had been having Warfarin at same dose, but as dose had not been prescribed I explained i had made a medication error. I tasked this error to the doctor to be reviewed and so that it could be prescribed correctly.	Reflection attached to datix. Human error - RGN has learnt from this mistake and will use this to improve her practice. Lessons learnt shared with team. Thankfully, no harm caused to patient - appropriate action taken post error.	Always check the 6 Rs of medication administration as per NICE guidelines.	Closed
GHC80215	29/11/2024	28/11/2024	18:30	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Prescribing	Amlodipine	No					Patient arrived on the ward at 18:30. Duty clerked patient in at 02:00 however did not prescribe any of their medications. Consequently no medications administered as instructed by ECT nurse prior to ECT.	Medics report that medications had been prescribed but not confirmed so as to avoid medications being given prior to ECT.	Appropriate action taken at time by medics to ensure medication not administered prior to ECT.	No new lessons learnt	Closed
										Missing medication	Prescribing	Levothyroxine	No									
GHC80267	30/11/2024	28/11/2024	12:19	LD Intensive Health Outreach	LD IHOT	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong quantity	Stock balance recording errors / discrepancies	COVID-19 vaccine	Yes	0.3ml/0.5ml		Intramuscular		The patient was given both COVID-19 and Flu vaccinations as requested by the GP, Parents, and Care home. All paperwork was completed before administering the vaccinations, GP confirmed in writing their agreement with our team administering vaccinations in the patient's Best Interest, and safety questions were asked on the day: 1) have they already had COVID and flu vaccinations this season 2) any previous adverse reactions to vaccinations Care team deputy manager answered no to both questions. Unknown to our team, the patient had already received both vaccinations at a pharmacy without a clinical hold: he was given the covid-19 vaccination on 16/10/24 and the Flu vaccination on 23/10/24.	All the verbal and written information provided by care team, GP and NOK was consistent, indicating that he had not previously received the vaccinations, and it was agreed to be in the patient's Best Interest for them to be administered (patient lacks capacity and unable to provide this information himself). Patient was in a clinical hold for another procedure, agreed by responsible clinician to be proportionate and in Best Interest, vaccinations were administered within the same clinical hold, increasing the restraint time by less than 1 minute. Those present believed that this was the least restrictive method to safely facilitate this procedure.	Staff hand over to team leader Lisa Clark review of notes provided evidence that there was a communication error between care staff and GP which lead to patient being vaccinated twice.	IHOT nurses will meet and make a plan of how to ensure such an error dose not happen again debrief will be held for staff involved in the incident	Closed
GHC80285	30/11/2024	30/11/2024	10:30	Wotton Lawn Hospital	Wotton Lawn-Abbey Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Methenamine	Yes	2g	1g	Oral	Oral	The patient had the medication when it was not due on the prescription, and the patient came to request another dose when it was due on the exact time with another staff.	It was confirmed from the staff that they had already been given, and the patient admitted and apologised for having come for another dose from another staff. The duty doctor was informed: the next dose would be omitted. The patient's physical observation was offered to be checked, but the patient declined to have the observation checked, and there were no issues or concerns on physical health or mental health to be reported.	Medication error protocol Discussed with doctor	none	Closed
GHC80326	01/12/2024	30/11/2024	09:00	The Vale Hospital	Vale Hosp- Peak View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Duloxetine	No					Patient's drug chart signed at 09.00am for a 30mg dose of Duloxetine when the medication for that dose was prescribed for 22.00pm. Spoken to nurse who signed the chart, who said that she did not administer that drug at 09.00am and accidently signed that box for that time. Patient consequently missed her 22.00pm dose on 30/11/24 as it looked like patient had already had that medication at 09.00am.	Staff nurse spoken to about incident and she will complete reflection and ward manager updated regarding incident. Patient informed of incident with apology - duty of candour.	Discussion had with nurse involved and reflection piece completed. Nurse has reviewed practice and completed medication competency. Apology given to patient and this was documented in notes. Doctor informed and no harm to patient through missed dose. Nurse distracted at time of incident and did not read paper chart correctly.	All staff should allow nurse completing medication round to do so without distractions. All staff need to remember the 5 Rs of medication administration and ensure a methodical approach to reduce the risk of errors.	Closed
GHC80343	01/12/2024	01/12/2024	12:30	Wotton Lawn Hospital	Wotton Lawn-Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong / unclear dose or strength	Prescribing	Venlafaxine	Yes	75mg	375mg	Oral	Oral	Patient known to me from community work and then during on call shift this weekend. Admitted 27/11/24 with psychotic depression. Some confusion over medication adherence in the community and so regular medication (Venlafaxine M/R 375mg OD and Quetiapine 150mg BD) not initially prescribed. Email sent to rectify this but only part of the antidepressant dose was prescribed - 75mg. Clinical deterioration noted in patient on routine review for another issue. Medication then checked and prescription error noted. Venlafaxine is high risk for discontinuation symptoms, which has likely impacted an already vulnerable mental state.	STAT dose of Venlafaxine given to make total daily dose to 300mg. Not increased to original dose initially due to theoretical risk of serotonin syndrome. Ward staff informed of error and to continue to observe closely for serotonergic symptoms and to monitor mental state.			Being Reviewed
GHC80395	02/12/2024	01/12/2024	20:45	The Vale Hospital	Vale Hosp- Peak View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Other (unlisted)	Yes	100ml/hr	100ml/hr	NG/PEG/PEJ	NG/PEG/PEJ	Patient in question is having Percutaneous endoscopic gastrostomy overnight feed that is due to commence from 20:30. At 03:00 it was noted to be beeping and when seen, it was noted that prescribed feed had not been running from set up. Line was primed, but start had appeared to not have been pressed.	feed was commenced at 03:00.	Incident reviewed. All staff reminded to check on medication such as this (i.e. set up to run over a period of time) at the beginning of their shift to identify that there are no issues. Staff member got distracted and did not press start once feed set up. Apology to patient not documented.	Staff should not be distracted whilst administering any kind of medication. For medication that is set up to be given over a period of time, staff have been reminded to check on progress routinely through the shift and at the beginning of the start of their care for that patient. Apologies to patients should be given and documented.	Closed
GHC80399	02/12/2024	02/12/2024	09:45	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Other (unlisted)	Yes	Unsure	20 units	Subcutaneous		During an insulin visit, patient who self administers insulin did not administer the full dose of one of their daily insulins. Insulin was first drawn up by nurse and handed to patient for self administration.		Reviewed with staff member and notes. GP was informed. Care staff were informed and advised to monitor blood sugar. RN visited later that day to review blood sugar. There have been a couple of incidents for this patient and I do not think she is able to safely administer now. Patient does struggle with dexterity. Advised team and reminder added to notes that DNs visiting will need to administer the insulin now for safety and to prevent any further errors.	DN have allowed patient to be independent as much as possible however too many incidents now of ? not receiving correct dose. DNs to administer insulin now.	Closed
GHC80486	03/12/2024	03/12/2024	10:00	The Vale Hospital	Vale Hosp- Peak View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Medication storage issue	Storage	Carbocisteine	No					Band 6 told Band 3 to get patient's TTO medication from the treatment room on the side as patient was due for discharge. Band 3 gave TTO's to band 5 (who thought that band 6 had checked the TTO's) Band 5 then went through the compliance box which was in the clear plastic bag against the patient medication that was in the drawer to give to the patient. Band 5 did not check the names on the loose medication in the clear plastic bag. Patient was then discharged home with wife. Wife later rang to say that in the clear plastic bag was medication for someone other than her husband.	Band 5 drove to patients house with the correct loose medication that was still in the TTO cupboard and not on the side in the treatment room. All medication was cross checked against TTO chart and patient left with the correct medication, other patient's medication was brought backj to the ward.	Incident reviewed and discussed with staff involved. All have recognised their part in the error. Medications to be retrieved from the treatment room by registered nurses only and to be checked against drawer and drug chart prior to being handed to patient.	Process for retrieving medication from treatment room has been reviewed. Only registered nurses should get this so that medication can be checked prior to be handed to the patient by an appropriately trained member of staff	Closed
GHC80517	04/12/2024	03/12/2024	20:49	The Vale Hospital	Vale Hosp- Peak View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Paracetamol	Yes	1gram		Oral	Oral	i accidently gave paracetomal just over two hours since the last dose	had to handover to night staff when i had just realised out of hours was contacted via 111 who rang back at approx 5:30am patient monitored overnight	Discussed with member of staff. She explained that she had been supporting 2 patients who were requiring very close supervision and this had been during the drug round. She had been very concerned that they might fall. the previous dose of paracetamol had been given 2 hours late and this had not been handed over to her. She did not check the time given when she administered the 4pm dose. She has reflected on this and will check previous dose times going forward. Medication timings were reviewed by ward doctor and amended to reduce risk of this happening again.	Staff should communicate with colleagues if drugs are not given on time. Staff should check the times of the previous dose to ensure that it is not given inappropriately. Staff have been encouraged to discuss with ward doctor if medication such as paracetamol is prescribed 4 hourly where there is a risk that the gap between medication rounds will be reduced.	Closed
GHC80539	04/12/2024	04/12/2024	11:00	NTQ management	Outreach Vaccination Team	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Other (unlisted)	Yes	0.3ml		Intramuscular		Person attended outreach vaccination session wishing to have covid vaccine. It was a busy session with queue and limited IT access. He stated that he had been due to have his vaccine recently but had cancelled that appointment due to being unwell and wished to have it today. When session became quieter and IT access obtained a vaccine was recorded as given 1 month before whilst he was an inpatient in Cirencester Hospital	09/12/24 Clinical Lead for NTQ projects. Further email correspondence filed in progress notes. Awaiting update from Lead Vaccinator after GP has been contacted as patient reported that they had not received a Covid vaccine in November or been an inpatient/attended Cirencester Hospital. 11/12/24 - update from GP surgery who confirmed the patients had an appointment for a Covid vaccination on 16/11/24 which he cancelled. Therefore the patient did not receive a vaccination on 16/11/24. Advised by GP surgery the Practice Manager would amend the patient's records on point of care system.	Appropriate action taken by contacting GP surgery to confirm patient's vaccination status.	As above	Closed
GHC80604	05/12/2024	04/12/2024	08:15	ICT	ICT Cotswold South 2 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Insulin isophane human	Yes	16 units Documented as 6 units	16 units	Subcutaneous	Subcutaneous	I noticed Humulin 1 recorded on S1 4/12/24 as 6 units and the patient is having 16 units of Humulin Insulin.	I think this a typing error. I mentioned to senior nurse and she advised i write a Datix.	Highlighted by staff that incorrect documentation noted on S1 No photo taken of drug chart to confirm what dose recorded on chart for Humulin I Prescribed 16 units Documented on S1 as administering 6 units Ongoing support being given to staff member	Ongoing support being given to staff member Regular clinical supervision and 121s being performed Well highlighted by diligent member of team	Closed
GHC80607	05/12/2024	05/12/2024	00:00	Sexual Health Service	Sexual Health Integrated ISH	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Pharmacy	Fexofenadine	No					Prescription sent to Pharmacy provider on 4/12/24, medication arrived back at Hope House on 05/12/24 for patient to collect, checked against prescription and 1 item had incorrect directions on.	Contacted pharmacy provider, staff member apologised and the item will be re-labelled and sent to Hope House tomorrow morning. Patient contacted and informed 1 item will not be available for collection today- they will still wanted come today to collect what is available.	Fairview Health Pharmacy to investigate December dispensing report received confirmed corrected directions	Fairview Health to investigate	Closed
GHC80631	05/12/2024	05/12/2024	14:00	ICT	ICT Cotswold North DN	Pharmacy-community	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Pharmacy	Hydrocortisone	No					On arrival at patient property to administer first does of Hydrocobalamin (B12), patient gave me the medication which was collected by her carer from the local pharmacy. The label was correct but the medication was three vials of Hydrocortisone. Advised patient I was unable to give this.	Took medication to GP Dispensary and explained what had happened. They said that they will report this and also request the correct medication to be dispensed to the patient ASAP.	thank you for reporting this incident Good identification of mis labelled medication Appropriate action taken at discover and no harm came to patient as a result of this incident	Discussed with Line manager and nurse identifying the error The dispensing pharmacy are reviewing to prevent further labelling errors Two similar medications - boxes similar stored next to each other in the pharmacy , they are reviewing this to change location of one or make it easier to identify which stock they are supplying. Drug checks prior to administration completed as should with all medications to prevent any harm or drug error	Closed
GHC80656	06/12/2024	04/12/2024	00:00	Sexual Health Service	Sexual Health Integrated ISH	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Pharmacy	Lamivudine + Dolutegravir	No					Prescription sent to Pharmacy provider for 2 months supply. Medication arrived back to Hope House and 6 months had been dispensed.	Rang Pharmacy provider, arranged to send 4 months supply back for credit.	Fairview Pharmacy to investigate Invoiced for correct quantity in December report	Fairview Health investigation	Closed
GHC80670	06/12/2024	06/12/2024	08:45	ICT	ICT Stroud BerkeleyVale DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Prescribing	Other (unlisted)	No					Collected insulin prescription chart from GP surgery as requested (requested to include updated BGL range) On arrival at patients property, noted new chart for 30 units and previously prescribed 38 units.	Checked patients S1 record, note letter from Diabetic specialist nurse requesting Chart prescribed for 38 units - utilised previous prescription chart and requested new one from surgery.	Correct action taken as wrong dosage not given and patient received the correct dosage.	This could easily of been missed as the chart for the medication had been written by GP who had written the incorrect dosage on the chart.	Closed
GHC80672	06/12/2024	12/10/2024	12:00	Charlton Lane Hospital	Charlton Lane-Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Memantine	No					The Patient's prescribed dose of memantine was not recorded as given, refused or any of the other recording options given on the patient's RIO medication chart.	Ward Manager and Hospital Matron were notified by Charge Nurse via the monthly missed doses audit results e-mail. The Medication Nurse concerned was asked to complete a reflection.	Handled in line with missed dose policy	NA	Closed
GHC80673	06/12/2024	13/10/2024	12:00	Charlton Lane Hospital	Charlton Lane-Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Memantine	No					The Patient's prescribed dose of memantine was not recorded as given, refused or any of the other recording options given on the patient's RIO medication chart.	Ward Manager and Hospital Matron were notified by Charge Nurse via the monthly missed doses audit results e-mail. The Medication Nurse concerned was asked to complete a reflection.	Handled in line with missed dose policy	NA	Closed
GHC80681	06/12/2024	16/10/2024	22:00	Charlton Lane Hospital	Charlton Lane-Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Atorvastatin	No					The Patient's prescribed dose of memantine was not recorded as given, refused or any of the other recording options given on the patient's RIO medication chart.	Ward Manager and Hospital Matron were notified by Charge Nurse via the monthly missed doses audit results e-mail. The Medication Nurse concerned was asked to complete a reflection.	Handled in line with missed dose policy	NA	Closed
										Drug chart errors - not signed, recording, other	Administration	Memantine	No									
										Drug chart errors - not signed, recording, other	Administration	Mirtazapine	No									
GHC80691	06/12/2024	03/12/2024	17:00	Stroud Hospital	Stroud Hosp- Cashes Green Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Pregabalin	No					At evening drug round, noted pot of tablets on bedside table.	Nurse in charge informed. Pregabalin destroyed in denaturing kit with 2 nurses. Tablets disposed of in medication waste bin. Administering nurse advised. Administration on SystmOne changed from administered to 'missed'. Datix under advisement.	Member of staff apologised, patient alert and orientated and would normally like to take his time to take his own medication. On this occasion he forgot to take them. Reminded staff of their responsibility when administering medications.	Staff reminded of their responsibilities when administering medications.	Closed
GHC80695	06/12/2024	05/12/2024	17:00	Stroud Hospital	Stroud Hosp- Cashes Green Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Medication storage issue	Storage	Oxycodone	No					Found controlled drug delivery not entered into stock or secured in CD cabinet. Left in treatment room, unattended.	After discovery, 2nd RGN asked to assist with entering CD into stock and secured in CD cabinet. Not possible to read signature of receiving nurse in CD stock ordering book. I signed the book to confirm had been received on ward.	Staff member identified.	All registered staff reminded of the responsibilities of medication storage and handling. Reminded to read policy. Added to safety brief. Discussed at ward meetings.	Closed
GHC80771	09/12/2024	08/12/2024	22:15	District Nursing (ENDS)	ENDNS- Out of Hours DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Controlled stationary (medication related)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Levomepromazine	No					Presented for visit in relation to catheter concerns (see S1 entry 8/12/24)- informed by wife during visit that patient had been unresponsive post administration of stat dose for pain (Morphine 5mg) and agitation (Midazolam 2.5mg) at 15:55. Patient unresponsive to voice and touch. On examination pulse thready and difficult to palpate, all other observations unreadable on medical devices- pinprick pupils noted. No swelling, no change in palor or rashes evident. Shallow breathing.	Escalated via 999 to explore possible reversible cause ?opioid related ?cerebral event. Ambulance contacted at 21:47. Breathing changes noted during call and all evidence of respiratory effort ceased at approx. 21:51. No active signs of breathing, pulse not palpable. Liaised with shift leads and OOH GP call-back requested. Stock check undertaken during interim period and discrepancies in JIC stock meds noted. Patient recently transferred to acute trust however no JIC meds taken with patient according to wife. Shift lead informed and escalated to OOH GP. Please note section regarding medical response selected as "No" due to no evident respiratory rate/effort noted (asked to count whilst on call however no active breathing at this time- respiratory effort ceased at this point in the call and 999 call handlers stepped down from any further escalation due to EOL/DNAR status).	Overnight staff member attended to review catheter as concerns by wife minimal output. Reviewed with bladder scan patient not drinking much Stat dose given that afternoon due to patient unsettled. Patient had fungating tumour - metastatic melanoma. Respect form highlighted not for CPR, however for active treatment for fracture. Patient passed away naturally very settled.	Lesson for future - Staff member to discuss with shift lead whilst in property for further guidance and discussion. Clinical supervision with staff member to discuss incident and potential EOL Masterclass.	Closed
GHC80789	09/12/2024	09/12/2024	11:40	Eating Disorders	Eating Disorder Community	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Controlled stationary (medication related)	None (no harm caused by the incident)	Missing controlled stationary	Controlled stationary							Email received from patient's father on 08/12/2024, explaining that patient has lost the completed community prescription script for Sertraline and Olanzapine, given to her + her mother on 03/12/2024.	Medications assessed to have low potential for harm or misuse if patient were to find the original script and have it dispensed so new script issued.	no requirement reviewed reported action at time of incident as appropriate response.	no obvious lessons learnt. Scripts once provided to patient, carer, parent can be lost. Important to determine the risks associated to misuse and in this particular incident the risks were low.	Closed
GHC80873	10/12/2024	10/12/2024	13:00	Tewkesbury Hospital	Tewk Hosp- Abbey View Ward	Other NHS Trust (please specify)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Pharmacy	Co-amoxiclav	No					A box of antibiotics received from the pharmacy as tto this morning. the prescription was stated as CO Amoxiclav 500mg/125 mg tablets and the box says the same strength but the strips inside the box had 250mg/ 125 mg tablets. the batch no. on the box matched the batch no on the strips inside.	- I have spoken to the medical team on the ward and we are now sending the lady with some antibiotics from our stock as patient is being discharged home today. - Spoke to the pharmacy and informed them about this- they advised to send the box back for them to investigate.	Discussed with Laura Bucknall Trust lead pharmacist who will discuss with pharmacy provider.	Ward correctly identified the discrepancy in the medication and informed Pharmacy provider. No harm to patient. Patient went home as planned.	Closed
GHC80877	10/12/2024	07/12/2024	12:00	Wotton Lawn Hospital	Wotton Lawn-Abbey Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Administration	Other (unlisted)	Yes	?	125ml	Oral	Oral	Fortisip Plant based 1.5 specific nutritional supplement, not administered as not present on the ward - staff have given a separate, entirely different oral supplement. Patient needs low lactose supplements, I believe a milk based supplement was probably given.	None - as staff unaware I have noticed this as ward needed the 'newly prescribed supplement' for the patient, as not delivered on the ward, but 3 days of either nurses giving the incorrect supplement or documenting 'medication not available' - it is ordered now and I have delivered some to the ward.	Staff followed policy and procedures, clinical documentation updated	Staff informed of error and reminded of process to follow	Closed
GHC80885	10/12/2024	05/11/2024	12:00	Charlton Lane Hospital	Charlton Lane-Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Cyanocobalamin	No					The Patient's medication was not recorded as given, refused or any of the other recording options given on the patient's RiO medication chart.	Ward Manager and Hospital Matron were notified by Charge Nurse via the monthly missed doses audit results e-mail. The Medication Nurse concerned was asked to complete a reflection.	Managed in line with missed dose policy	NA	Closed
										Drug chart errors - not signed, recording, other	Administration	Cyproterone	No									
										Drug chart errors - not signed, recording, other	Administration	Diazepam	No									

										Drug chart errors - not signed, recording, other	Administration	Haloperidol	No									
										Drug chart errors - not signed, recording, other	Administration	Promethazine hydrochloride	No									
GHC80888	10/12/2024	30/11/2024	12:00	Charlton Lane Hospital	Charlton Lane-Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Apixaban	No					The Patient's prescribed morning medication was not recorded as given, refused or any of the other recording options given on the patient's RIO medication chart.	Ward Manager and Hospital Matron were notified by Charge Nurse via the monthly missed doses audit results e-mail. The Medication Nurse concerned was asked to complete a reflection.	Managed in line with missed dose policy	NA	Closed
										Drug chart errors - not signed, recording, other	Administration	Cyproterone	No									
										Drug chart errors - not signed, recording, other	Administration	Flucloxacillin	No									
										Drug chart errors - not signed, recording, other	Administration	Gliclazide	No									
										Drug chart errors - not signed, recording, other	Administration	Memantine	No									
										Drug chart errors - not signed, recording, other	Administration	Metformin	No									
										Drug chart errors - not signed, recording, other	Administration	Other (unlisted)	No									
										Drug chart errors - not signed, recording, other	Administration	Paracetamol	No									
GHC80889	10/12/2024	30/11/2024	21:30	Charlton Lane Hospital	Charlton Lane-Willow Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Paracetamol	No					The Patient's prescribed dose of paracetamol was not recorded as given, refused or any of the other recording options given on the patient's RIO medication chart.	Ward Manager and Hospital Matron were notified by Charge Nurse via the monthly missed doses audit results e-mail. The Medication Nurse concerned was asked to complete a reflection.	Managed in line with missed dose policy	NA	Closed
GHC80910	11/12/2024	26/11/2024	10:45	ICT	ICT Cotswold South 2 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Ordering, collection or delivery	Hydroxocobalamin	No					Visited patient to support a colleague with supervision of B12 injection. No injection present in property or drug lockbox on arrival, so unable to administer, after last administration no appointment had been booked to organise ordering of medication and no collection had been arranged with care company. Patient has no family nearby to assist with collection.	Apologised to patient, patient has dementia and is unable to manage ordering herself. Surgery contacted and medication ordered. Care company telephoned and asked to collect as soon as it was available. New appointment booked for following week.	Patient administered b12 on 18/12/24 Confusion around dispensing and collection of medication Notes reviewed and TASKS sent directly to staff members from Surgery and GP will only issue 1 ampoule at a time	Will share at team time If TASKS being sent to surgery to ensure that sign off states to not reply directly to staff member but to TASK referral centre Onward appointments made prior to next due date to request medication and arrange collection	Closed
GHC80916	11/12/2024	11/12/2024	08:30	ICT	Reablement Forest	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Ferrous fumarate	Yes	1 tablet	1 tablet alternate days	Oral	Oral	Patient discharged from hospital yesterday, has ferrous fumerate to be given on alternate days, given today in error, it should have been a missed day	spoke to pharmacist to check what to do, recorded and reported to rco	advice from pharmacy received from RW and actioned. No immediate concern to the patient, safety netting advice given. Identified human error-MARS chart correct. RA aware of mistake and reported independently- advised to be more vigilant when reading MAR charts.	RW aware of mistake and reported independently- reminded to be more vigilant when reading MAR charts and double checking everything. This is a one off event for this particular staff member- no additional training required at this time.	Closed
GHC80942	11/12/2024	10/12/2024	14:00	Recovery	Recovery Gloucester	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Ordering, collection or delivery	Clozapine	No					A support worker came to collect medication for 2 patients i was on triage so gave them over however gave the wrong medication over for one of the patients. less than a hour later the support worker brought the medication back and told me if given the wrong one. I gave them the correct one. I checked the medication it was not opened and still correct so I locked it away.	Nothing	Reporter is new member of staff and on preceptorship. Preceptee advised and supervisor so reminder of SOP and importance of checking medications thoroughly before they are signed out Name of other patient seen by care staff who has understanding of confidentiality understood and not patient/informal carer, likelihood of distress in patient being informed that their personal information was shared decided on.	Individual learning as newly qualified RMN, to be consolidated and reflected on in supervision. Tools such as writing down names rather than relying on memory (particularly when more than one patient names as in this instance and as likely interruptions between task may occur) advised to support reduced likelihood of mistakes and checking with person with view of confidentiality if in reception space, the name to be sure medications given are correct.	Closed
GHC80944	11/12/2024	29/11/2024	14:16	Wotton Lawn Hospital	Wotton Lawn-Kingsholm Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Promethazine hydrochloride	Yes	150	100	Intramuscular	Intramuscular	It was found through Audit conducted on 3.12.24 that service user was given 150 mg of Promethazine over a 24 hour period on 29.11.24 and the later 2 doses were given in an hour difference . The record of administration are as follows: 01:39 -50 Mg Tab 13.03- 50 mg Tab 14.16- 50 mg IM	Spoke to staff nurse who was completing the medication round on 29th. Staff nurse informed charge nurse that this was given as per ward doctors advice. Escalated with ward medics who confirmed that this was not communicated with them. Staff nurse was unable to recollect whether the communication was with duty doctors. Spoke to staff explaining this and requested for reflective account. Reflective account received from staff on 10.12.24.	Investigation commenced to identify circumstance of this medication error, staff member concerned advised that medication was given with medics consent, however investigation has been unable to confirm this. Staff member was requested to provide a reflective piece in line with medication error policy, this was completed and staff member has acknowledged the concerns and need for accuracy in administration of medications to patients.	Staff member was able to provide a reflective piece in which best practice was highlighted and assurances from staff member that administration policy would be followed precisely.	Closed
GHC80964	11/12/2024	03/12/2024	17:30	ICT	ICT Cotswold North DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong / unclear dose or strength	Preparation by administering clinician(s)	Insulin lispro	Yes	12 units	10 units	Subcutaneous	Subcutaneous	Went in to patient for routine evening insulin administration on 06.12.24 - insulin administered as prescribed - BGL in range noted: Insulin administration 3 Dec 2024 17:30 pm glucose reading 13.8 mmols - Insulin documented as given 12 units lispro on drug chart _ 12 units on s1 also documented Next evening 17:00 pm documentation on chart reading BGL below 15 again , documented as giving 12 units on drug chart - 10 units given on s1	Patients BGL stable at visit and prior to this patient was usual self- incident 48hrs prior to this visit- no additional action taken at visit- patient has libre device which is checked regularly- has twice daily DN appointments and has live in carer. Wanted 2nd check by Senior to ensure information noted was drug error. Spoke with senior, picture of drug chart sent	Reviewed drug chart and notes on systemone. Discussed with nurse who visited on this day, she was unable to remember if she gave the dose documented on the drug chart and systemone. Nurse advised she always looks at the prescription on the front of the patients drug chart and follows the sliding scale, so feels she would have given the correct dose. We discussed the importance of correct documentation and informed the nurses line manager to follow up in 121 and clinical supervisions.	Thank you for raising this datix for the nurses learning. Further follow to be completed by the nurses line manager.	Closed
GHC80977	12/12/2024	12/12/2024	02:00	District Nursing (ENDS)	ENDNS- Out of Hours DN	GP	Medication incidents	Controlled stationary (medication related)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Prescribing	Midazolam	Yes	2.5mg	2.5mg	Subcutaneous	Subcutaneous	went out to visit a palliative patient overnight to administer a stat dose. noticed drug chart didn't have a start date on it. stat dose already given earlier in the day. can see from system one notes that GP issued JIC meds and chart on 10/12/24 chart was signed just no date written on chart.	system one notes checked stat dose given datix completed written order from OOH GP attached to records.	Routinely visit patient daily for insulin administration. District nursing sister attended in day time to administer stat doses at 6pm. No evidence of concerns of clerical information on drug chart. 10th December GP documented that new drug chart required as needing to from morphine to oxycodone Stat doses given from 11th December with no start date.	To share learning with locality as multiple staff members signed drug chart from the 10th December with no start date. Changed from no harm to near miss. Uploaded email from OOH to clarify the confirmed start date. Uploaded drug chart on to datix for evidence of error	Closed
GHC81003	12/12/2024	12/12/2024	08:30	Integrated Urgent Care Service	IUCS OOH Service	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Medication storage issue	Storage	Amoxicillin	No					3 OOH medication cases were left out of the medication cupboard on the couch in the OOH treatment Room (Room 7)at GHFT OPD. One of the cases was not sealed The drug cupboard keys were left in the lock of the cupboard and not secured The issues was identified by GHFT OPD staff when they came on duty this morning	GHFT staff put the medication cases in the medication cupboard and have put the keys in the Sisters office for collection this evening.	Appropriate action taken, staff comms sent out and regular Medication management audits commenced	improved medication management processes	Closed
GHC81024	12/12/2024	12/12/2024	17:00	ICT	ICT Stroud BerkeleyVale DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Morphine	Yes	5ml (10mg)	1.25ml-2.5ml (2.5mg-5mg)	Oral		Visited patient at home for buprenorphine patch application. On arrival husband of patient disclosed that he had been giving patient 5mls of oramorph at each dosing interval which is double the prescribed dose of 2.5mls.	Explanation given to patient's husband of how much oramorph to give each time. Buprenophine Patch now in situ to try and reduce reliance on breakthrough medication. Informed GP and task sent for advise.	No action, feel it was dealt with appropriately and followed up with GP.	None	Closed
GHC81030	12/12/2024	11/12/2024	19:50	Forest of Dean Hospital	FoD Hosp-Woodland View Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Oxycodone	Yes	5mg	10mg	Oral	Oral	When administering 20:00 medications noticed that medication had not been signed out of CD register but had been signed on System One as administered. Patient was prescribed 10mg of Longtec. Counted medications and they were correct so the 10mg of Longtec could not have been administered from the stock CD cupboard, Checked Patient's own medications cupboard and there were no medications for the patient.	Looked through CD register to see if we could see if another medication that was administered instead of prescribed drug. We found that Longtec 5mg had been signed out and given at the time it had been signed for on system one by the same nurses who had signed the medications.	patient had been previously prescribed longtec 5mg am and pm , prescription got changed in the afternoon to 5mg am and 10mg pm. oversight by staff administering. discussion with staff members involved during clinical supervision. no ill effects to patient, prn oxynorm was available if required.	staff reminded of the importance of due diligence when administering and countersigning drugs as often medication prescriptions can be changed without nurse on duty being notified	Closed
GHC81080	13/12/2024	10/12/2024	08:15	ICT	Reablement TNS	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Losartan	No					Losartan and Omeprazole not administered to patient during AM visit.	Incident noticed at 1700 on 13/12/24. I SCNA Kristina Gibney who advised that no further action is required as the incident occurred more than 48 hours ago and the patient is End of Life Care.	orange folder reablement notes reviewed	thank you for raising, notes reviewed and evidence of medications given 10/12/24 may be worth trying to pick apart where you thought error occurred please discuss further with line manager/me	Closed
										Drug administration omitted / delayed	Administration	Omeprazole	No									
GHC81149	15/12/2024	14/12/2024	13:00	North Cotswolds Hospital & GMC	NC Hosp-Cotswold View Ward	Great Western Hospitals NHS Foundation Trust	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Drug administration omitted / delayed	Administration	Ethosuximide	No					Patient arrived from acute hospital without critical timed medication for management of epilepsy.	Ward from where he had previously been cared for contacted. They said the medication had been sent but he did not arrive with any. His wife was called, they have medication but no-one is able to come to the ward to deliver it. Current ward doctor completed an FP10 but no local pharmacies had the medication in stock. 111 contacted, their doctor advised it would be safe to miss a couple of doses. Explained the situation to the patient and apologised for it happening.	Ward sister tried to source medications from discharging ward (OOC hospital 30 miles away), from patients family and from local pharmacies, with no success. Spoke with OOH DR who advised would need to miss doses as no other real option. Wife happy to bring in meds following day, which she did. Patient aware and apology given to him for missing doses.	Patient not sent with medication from discharging ward, arrived at weekend. ward sister tried to source medication from all local chemist, none of which stocked it. Discussed with OOH and advice from them followed.	Closed
GHC81157	15/12/2024	15/12/2024	09:00	Recovery Units	MH IP Rehab-Laurel	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administered when stopped	Administration	Lamotrigine	Yes	100		Oral		Patient using compliance aid for 6 days which contains Lamotrigine 100mg BD which they are no longer prescribed.	Duty doctor called- Advised to continue with current Lamotrigine dose and for the regular doctors to review this tomorrow. Advised Patient of current error and explained plan	Duty doctor called- Advised to continue with current Lamotrigine dose and for the regular doctors to review this tomorrow. Advised Patient of current error and explained plan Nursing team advised to check the dates on compliance aids and to check the scripts inside, to ensure that correct medication is given.	Reminded the nursing team to ensure that the dates on compliance aids are checked as, out of date ones may contain the incorrect medication.	Closed
GHC81158	15/12/2024	14/12/2024	16:55	Wotton Lawn Hospital	Wotton Lawn-Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Use / possession of over-the-counter (OTC) medicine	Paracetamol	Yes	2 gram		Oral		-Patient went on unescorted leave , upon return search was completed after gaining consent , found a packet of paracetamol. -Self reported taking 04 paracetamol along with vodka. -DMO was informed -Bloods were taken. -Physical observations taken.	-DMO was informed -Bloods were taken. -Physical observations taken.	PROCESS FOLLOWED	N.A	Closed
GHC81162	15/12/2024	14/12/2024	19:00	Crisis Resolution Home Treatmt	CRHT West Glos	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Adverse / allergic drug reaction (when used as intended)	Administration	Duloxetine	Yes	60mg		Oral		Patient was prescribed Duloxetine 60mg from medic and took first dose, where he experienced the following symptoms: *vomiting *dizziness *unconscious periods *Low BP episodes Ambulance was called by patient who attended and deemed him medically fit not requiring further treatment, but patient declined to go to A+E even if this was needed.	Ambulance called Advise given Support call made Booked in urgent medical review	Patient was booked in for medical review where medication was reviewed. Discussion and reflection with team involved.	None, isolated incident and managed appropriately by team at time.	Closed
GHC81192	15/12/2024	13/12/2024	12:00	Recovery Units	MH IP Rehab-Honeybourne	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Use / possession of over-the-counter (OTC) medicine	Co-codamol	Yes	32/2000	16/1000	Oral		Patient woke and immediately used period of leave from the unit. Patient attended local pharmacy. On return to the unit patient made it clear that they had bought co-codamol 8/500 from local pharmacy. They had bought this to manage ongoing pain. Patient then took 4 tablets in front of staff despite attempts to engage and de-escalate.	Staff engaged with patient throughout, staff able to remove remainder of medication from patient through engagement. Patient offered support and physical observations completed. Regular pain medication omitted. Leave revoked.	Patient self administered themselves with pain relief that was not prescribed by the unit.	Patient supported. Prescribed pain relief not given. Risk assessment review and updated following changes to patients leave being made.	Closed
GHC81200	15/12/2024	15/12/2024	20:00	Recovery Units	MH IP Rehab-Honeybourne	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong quantity	Use / possession of over-the-counter (OTC) medicine	Paracetamol	Yes	16000		Oral		Patient returned from leave with family, on returning to the unit patient's partner reported patient had taken paracetamol. On approaching patient they indicated they had taken two boxes of paracetamol over the time period they were out. Patient was clear in explaining this was due to ongoing fixation on physical health and the pain they experience. Patient appeared to have taken upto 32 tablets in two separate administrations to manage pain. Although patient unable to be exact. Patient reported having stolen the medication from family.	Staff spent time with patient de-escalating, eventually leading to patient allowing staff to search and finding further medication. Patient reported feeling sick but not having thrown up. Dr contact. Patient escorted to GRH to monitor for overdose. Family contacted.	Review of patient management on the unit, patient returned to unit safely with no long term concerns of presentation. Ongoing safety netting being developed for patient whilst on unit.	Appropriate management by staff on shift, learning regarding the ability to manage and tolerate ongoing risk to self where staffing contingent unable to respond to demand, due to staffing levels and isolation of unit.	Closed
GHC81217	16/12/2024	14/12/2024	08:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Morphine	Yes	10mg		Oral		Zomorph administered to patient twice, signed on EPMA but not in CD book for whole day.	Discrepancy identified and as per SOP, entry in CD book to clarify error. All tablets accounted for, error is the appropriate recording in CD book. Ward manager to discuss with nurses involved - to complete supervised drugs round, reflections and refresh elearning related to CD medication.	Appropriate action taken at time of incident Nurses have completed reflections	No further lessons identified	Closed
GHC81220	16/12/2024	16/12/2024	11:35	Wotton Lawn Hospital	Wotton Lawn-Kingsholm Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	Moderate (significant but not permanent harm e.g. takes up to 1 year to rectify)	Missing medication	Stock balance recording errors / discrepancies	Co-codamol	No					Missing controlled drug medication identified: Cocodamol 30mg/500 mg- 7 tablets Co-codamol 15mg/500 mg 63 tablets Codeine 30 mg : 21 tablets	Stock check completed. Check of signing sheet recently introduced (completed in part). Datix submitted. Email to matron to inform. Call to pharmacy to inform and request meeting (planned for 17/12/24 @ 13:30) - meeting held, information sharing regarding incident, agreed to continue 2x qualified staff to sign using CD book and stock check when medications administered. Stock history to be compiled by pharmacist, check on last 'top-up' occurred. Expectations to be reiterated to staff regarding management of CDs. Plan to stock check co-codomol / codeine on daily basis.			Being Reviewed
										Missing medication	Stock balance recording errors / discrepancies	Co-codamol	No									
										Missing medication	Stock balance recording errors / discrepancies	Codeine	No									
GHC81237	16/12/2024	16/12/2024	15:00	Homeless PH	Homeless Healthcare Team	Other organisation (please specify)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong quantity	Administration	Diazepam	Yes	unknown		Oral	Oral	Pharmacy alerted us to carers asking for more diazepam and admitting to giving more than prescribed so has now run out	Unable to contact carers as not answering phone Safeguarding contacted Safeguarding form submitted datix completed	Escalated to senior management team due to team concerns.	Ongoing learning with this SAS patient	Closed
GHC81247	16/12/2024	16/12/2024	16:30	ICT	ICT Chelt St Paul's DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Other (unlisted)	Yes	5000 units	5000 units	Subcutaneous	Subcutaneous	Arrived for daily fragmin and noted that drug chart was not filled out on previous day. Visit recorded on system one so medication was given	Daily injection given and datix to be completed	Notes checked and visiting nurse has documented the medication was given to patient the previous day. Paper copy of drug chart was not signed.	Staff member to be informed of above.	Closed
GHC81251	16/12/2024	16/12/2024	18:00	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Insulin lispro	Yes	?30 units	12	Subcutaneous	Subcutaneous	Visited patient for PM dose of insulin. Evening dose 12 units. No entry on blue evening drug chart for yesterday. CHecked day time chart and PM visit was documented on there, and was documented that patient has had 30 units- this is the AM dose. Checked S1, evening care plan for 12 units has been completed. However, 30 units is also documented in patient notes as being administered.	Patient BGL is stable and no problems or concerns. Datix completed as unsure as to which dose the patient has had.	15.12.2024 Patient reviewed by OOHs GP due to concerns around patient running higher BGLs. During the week BGLs have been running in mid-late 20s. Planned for home visit to review ? BGLS caused by UTI. 15.12.2024 Routine DN visit for am insulin administration. RN assessment completed no concerns raised - NEWS score within normal range. Routine visit seen at 16:10 for pm insulin. Records indicated that morning dose of insulin given not evening dose. Care plan not used. Records on drug chart signed for morning dose not evening dose. Error not highlighted until 16.12.2024	Discussion with staff member, including implications of drug error. Staff member advised that was not aware of differing drug charts for day and evening insulin administration. Learning shared at Team time and minuted. Session provided for staff member to go through drug charts to be more aware of 6'Rs difference in day and night insulin drug chart. Reflection requested to be added to P file	Closed
GHC81302	17/12/2024	17/12/2024	15:00	ICT	ICT Cotswold South 2 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Administration	Other (unlisted)	Yes	100ml		Other		Visited patient for routine bladder washout Has both citric acid 3.23% and Saline 0.9% bladder washouts available Twice a week should have citric acid administered via urethral catheter Drug chart supports this Noted that on 4 separate occasions with 4 separate members of staff had administered saline 0.9% despite chart indicating for citric acid	Photo taken of drug chart and checked instillation template on S1 This confirms error has occurred and wrong bladder washout used Datix completed Email sent to Band 6 to discuss with member of staff at next 121 RN Sloman has allocated to team ledgers to discuss with them at earliest opportunity	Multiple blockages/ sediment in urine S/B Urology in October 2023.GP prescribed citric acid bladder irrigation since 23rd October 2023 Planned cystoscopy arranged by Urology team. Following cystoscopy recommendation for bladder washouts however no indication specific type. Drug chart stating for administration of citric acid not saline. 26/11/2024 initial error with administering saline bladder washout - no clinical rationale for using saline bladder washout 1/12/2024 error with administering saline bladder washout 3/12/2024 Citric acid bladder washout administered as prescribed 6/12/2024 Saline bladder washout administered with no rationale 10/12/2024 stated in patient notes by RNA that Saline bladder washout given as no citric acid available No harm has come to the patient - no blockages or issues with catheter	Routinely Urology do not advise to administer citric acid bladder irrigation on a permanent basis therefore this prescription will need to be reviewed. Requires deep dive with senior community nurse regarding this. Routinely citric acid is used for crystallisation not sediment Incorrect administering of medication - to share at Team Time and minute the meeting. Share at B6 Governance meeting for learning	Closed
GHC81332	18/12/2024	06/12/2024	11:15	ICT	ICT Glos North South DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Other (unlisted)	No					Missed Oral Medication	Documented Reported to DN	Missed medication from the previous day - medications still in the dosette box. S1 checked and nurse visiting previous day documented medications were prompted. I will discuss with visiting nurse. No harm to patient.	Continue to datix any medication errors.	Closed

GHC81354	18/12/2024	13/12/2024	20:00	Crisis Resolution Home Treatmt	CRHT West Glos	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Quetiapine	No					Attended patients property for medication management on 15/12/24 to find that patient had missed dose of quetiapine 300mg on 13/12/24. Patient explained that he did not know why he did not take it and has continued to be compliant with all medications since then.	Education given on medication compliance, and the risks of not taking medication consistently. Advised senior staff of incident. Monitored compliance further.	Reflection with staff member involved. One of the difficulties of positive risk taking in the community and is reviewed frequently by CRHT staff. Staff member involved appeared to manage situation well.	None, demonstrated good care	Closed
GHC81380	19/12/2024	22/11/2024	06:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Other (unlisted)	No					During the Missed Dose Audit for November 2024, a missed dose was identified during the 06:00 drug round.	As this was a bank nurse, temp staff have been contacted to request a reflection from the nurse.	Reflection from nurse involved	No further lessons identified	Closed
GHC81450	20/12/2024	13/12/2024	11:45	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Other (unlisted)	No					I went to see the patient to administer his daily insulin and his weekly Trulicity, but on the drug chart it had already been signed for on the 12/12/24.	I checked the other drug chart for his bladder wash out and could see it was not signed for. Patient and next of kin confirmed he did not have the injection. I called the lead RN who advise me to contact the person that went in the day before to check she had not administered the Trulicity. Confirmed it had not been given and administered as needed.	Reviewed notes - patient has received medication as prescribed. Documentation error when signing drug chart Spoke to healthcare assistant - and thanked them for the way they handled the issue and for raising the datix Staff member involved in signing error is an agency nurse - will discuss with them in new year when they return from leave	Human error - staff member made aware	Closed
GHC81458	20/12/2024	20/12/2024	10:30	Homeless PH	Homeless Healthcare Team	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Moderate (significant but not permanent harm e.g. takes up to 1 year to rectify)	Drug administration omitted / delayed	Administration	Promethazine hydrochloride	No					Phone call from patients carers (Bosun Care) asking for us to send a script to the pharmacy as Promethazine is missing and the pharmacy needs a script to issue. Checking S1 the scripts have all been issued and that it may be a pharmacy issue, advised they contact the pharmacy. We then receive an email from the pharmacy saying that the carers have been in asking for more medication as they have 'got rid' of the last lot but now realise they need it. I contacted the pharmacy and they tell me that they have had many issues surrounding medication with this care team looking after this patient, and now document very differently when issuing medication to the for the patient. They now have to sign for everything. I have asked for this to be sent over to us.	Spoken with the Pharmacy team. Contacted the Bosun Care manager Gemma to discuss and highlight my concerns. We will update social care re new issue's with medication, as other datix and concerns have been raised. Datix completed.			Being Reviewed
GHC81462	20/12/2024	20/12/2024	09:40	ICT	Reablement Cheltenham	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Mometasone	No					once a day am missed medication on 19/12/24	medication given correctly 20/12/24. Reported missed medication to Reablement lead who will arrange to contact Reablement worker on 19/12/24 to investigate.	discussion with training lead and worker re medication best practice	best practice re medication discussion had between training lead and worker	Closed
GHC81470	20/12/2024	20/12/2024	09:00	ICT	Reablement Cheltenham	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Procyclidine	Yes	2.5mg		Oral		Medication incorrectly written onto Medication Administration Record. No plan in place to support patient with prescribed dose of half a tablet prior to arrival of pill cutter device	patient reported that he could cut the tablet himself and demonstrated that he was able to do this safely and take the half dose. Patient also reported that pill cutter should be delivered today.	discussed with training team lead who identified the incident - discussion with her and worker on best practice for medication	staff feedback and learning shared	Closed
GHC81478	20/12/2024	19/12/2024	17:16	Montpellier Secure Inpatients	Montpellier Low Secure Unit	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong route	Administration	Haloperidol	Yes	5mg	5mg	Intramuscular	Oral	A patient who was displaying acute distress and agitation in the context of psychotic disturbance was given Rapid Tranquilization medication. This was administered via Intramuscular Injection however the prescription chart specified the route of administration as Oral.	On discovery of the medication error, the member of staff who made the error has been offered and accepted supervision. The staff nurse has agreed to write a reflective account of what happened and has been offered extra support with regard to medication administration.	Supervision with nurse who administered medication. Reflection complete. Patient informed.	Managing stress during challenging situations and self-awareness on attention to detail to minimise errors.	Closed
GHC81486	20/12/2024	19/12/2024	15:00	Wotton Lawn Hospital	Wotton Lawn-Abbey Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Methylphenidate	No					CD2 and CD3 drugs within patient "leave" TTOs not recorded in the Patient's Own CD record book (not recorded anywhere) and not kept in the CD cabinet. Excess TTOs with CDs present in cabinet (6 bags). Drugs included methylphenidate and tramadol. Some doses were clearly missing from the boxes they were dispensed in.	Reported to AO for destruction	Ward manager has first hand knowledge of this event: Patient medication prescribed to was going on leave - normal TTOs arrive in one bag, TTOs with CDs in separate bag and stored separately. Staff nurse trying to locate TTOs for patient concluded that TTOs were incorrect as the CDs weren't in the normal TTO bag. Patient becoming increasingly agitated. Ward manager asked to assist - CD TTOs located and amalgamated with normal TTOs - forgot that these would have been recorded and required accounting for due to: a) length of time since manager last dealt with CD TTOs b) vast quantity and variety of TTOs that took a significant period of time to check c) increasingly agitated patient which made the situation more pressured as it was highly important that leave period occurred and was overall positive	Refresher training for CD procedures for all staff would likely prove useful	Closed
GHC81489	20/12/2024	19/12/2024	15:00	Wotton Lawn Hospital	Wotton Lawn-Abbey Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Cannabidiol	No					3 entries of unknown substances recorded in patient's own CD record, but no record of these being destroyed, given to patient, or administered. No way to trace what happened to these substances (not in CD cupboard for destruction) and therefore, can only be considered as missing/unaccounted for.		Unable to trace what has happened to said organic matter - no idea what this was - occurred several months ago - no way of knowing if this had been destroyed or disposed of in another manner. Ward manager has no suspicion of any staff member removing item other than to destroy it, nor any evidence to suggest otherwise	Refresher training for CD procedures for all staff would likely prove useful	Closed
GHC81490	20/12/2024	19/12/2024	15:00	Wotton Lawn Hospital	Wotton Lawn-Abbey Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Cannabidiol	No					2 bottles of "organic matter" listed in patient's own CD record book, but no record of this being destroyed/given to patient/administered etc. Said bottles of organic matter not in CD/medication cupboards.		Unable to trace what has happened to said organic matter - no idea what this was - occurred several months ago - no way of knowing if this had been destroyed or disposed of in another manner. Ward manager has no suspicion of any staff member removing item other than to destroy it, nor any evidence to suggest otherwise	Refresher training on CD procedures for all staff would likely prove useful	Closed
GHC81491	20/12/2024	19/12/2024	15:00	Wotton Lawn Hospital	Wotton Lawn-Abbey Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Methadone	No					Methadone recorded in patient's own CD record book with no record of medication being administered, destroyed, or returned to patient. Therefore, considered missing/unaccounted for.	Alerted AO	Unable to ascertain exactly what has happened to the 1ml of methadone - it seems most likely that, given this is such a small amount of liquid within a bottle, staff member mistook the bottle as being empty and disposed of it	Refresher training on CD process would be useful Also worthy of consideration is the confusion that having separate places for recording CDs causes	Closed
GHC81492	20/12/2024	19/12/2024	15:00	Wotton Lawn Hospital	Wotton Lawn-Abbey Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Missing medication	Stock balance recording errors / discrepancies	Midazolam	No					Buccal midazolam recorded in Patient's own record book, with no record of this being administered, destroyed, or returned to patient. Assume missing/unaccounted for.	Alerted AO	Investigated by ward manager - noted medication recorded in patient own CD book. Numerous doses administered to patient via EPMA, although not recorded in CD book. Cross referencing subsequent pharmacy deliveries recorded through ward CD book, patient own CD book and EPMA meds admin, satisfied that this all correlates and the error was staff not recording administration within the CD book	Refresher session for all qualified staff on the ward in relation to CD administration process	Closed
GHC81494	20/12/2024	19/12/2024	15:00	Wotton Lawn Hospital	Wotton Lawn-Abbey Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Medication storage issue	Storage	Thiamine	No					x2 boxes of Pabrinex found in drug cupboard (non-refrigerated conditions).	DATIX	Ward management team informed ward staff of error and advised about correct storage	none	Closed
GHC81521	21/12/2024	19/12/2024	10:00	Recovery Units	MH IP Rehab-Laurel	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong time / frequency	Administration	Colecalciferol	Yes	400		Oral		TTO chemi pack was used as regular medication.	The TTOs had to be ordered again at short notice as the TTOs medication had been used on a few separate days. The TTO chemi pack was therefor incomplete. Dr requested new chemi pack to be delivered in time for xmas leave.	Nursing team reminded to ensure that chemi packs are ordered on time, to ensure that TTO's are not needed for regular medication.	Nursing team advised to diarise a day a week to ensure that all medications and TTO's are ordered on time.	Closed
										Wrong time / frequency	Administration	Lurasidone	Yes	18.5		Oral						
										Medication storage issue	Storage	Mirtazapine	Yes	15		Oral						
GHC81532	21/12/2024	20/12/2024	03:00	CYPS/PH Community Specialist	CYPS/PH-Children Complex Care	Pharmacy-community	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Medication storage issue	Pharmacy	Paracetamol	Yes	5 millilitres	5 millilitres	NG/PEG/PEJ	NG/PEG/PEJ	Patient due a dose of paracetamol in family home due to high temperature overnight. Bottle of medication received from pharmacy yesterday in use by parents is a plain black glass bottle with nothing to identify that it is paracetamol. The pharmacy label attached is complete and correct however there is no expiry date on the bottle or label. Family have attached pink sticker to identify the opening date of 19/12/2024. Clarification with Care Coordinator during shift that if no expiry is present on the bottle, to assume the expiry is 3 months from opening date. Concern subsequently raised by Care Coordinator that the bottle does not clearly identify that it is paracetamol other than the pharmacy label attached and that perhaps we should not be using this as there is a small risk that the contents are not as suggested. Family have another bottle of branded Calpol which has got a prescription label on it so we can use that one instead. Family to return the unbranded bottle.	Advice sought from Care Coordinator. Advice given was as per trust policy and in line with expectations of the team.	No further action required - Action taken was in line with the organisations and teams policies and procedures	Good practice is embedded in the team.	Closed
GHC81543	22/12/2024	21/12/2024	10:00	ICT	ICT Glos HQR DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Insulin glargine	No					Attended to patient for insulin 22/12/24 - Insulin chart not signed from day before. System one checked and no documentation to confirm if visit had been completed. Asked patient if he had visit yesterday but could not recall	Missed visit documented in notes. BGL checked today and within range, Datix completed	Thank you for reporting this Datix. The patient had refused his insulin on the day in question. The nurse had failed to put the refusal code on the drug chart. Plan to ensure the nurse is reminded to document a refusal.	As above	Closed
GHC81561	22/12/2024	21/12/2024	10:20	ICT	ICT Cotswold South 1 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Dalteparin	No					Missed appointment and therefore 1 missed dose of daily dalteparin.	Spoke to 111 who advised me to call the pharmacist. Pharmacist stated that if no signs of DVT and pt feeling well, to continue with daiky dalteparin injections.	Notes reviewed No harm noted and correct action taken Patient completed course of medication without issue	Missed visits already noted as a trend currently being reviewed and discussed to reduce risk of missed visits	Closed
GHC81608	23/12/2024	21/12/2024	08:00	Wotton Lawn Hospital	Wotton Lawn-Abbey Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Prescribing	Aripiprazole	No					Oral aripiprazole order was prescribed but not confirmed, therefore pt missed Saturday and Sunday dose.	Error discovered Monday and nursing team made aware to administer dose ASAP	Prescriber reminded of need to validate/confirm prescriptions	Need for prescribers to confirm all prescriptions otherwise invalid. Make sure locum as well as substantive staff are aware.	Closed
GHC81652	24/12/2024	24/12/2024	10:00	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Supply issue	Ordering, collection or delivery	Docusate sodium + Glycerol	No					Patient does not have docusate sodium in their TTO medication to be sent home over the Christmas period for 2 nights overnight leave.	Dr informed - they have had a conversation with Patient about this. He will have his 12.00 dose at 11.00 before he goes on leave today and therefore should only be missing two doses when on leave. Patient and doctor and charge nurse have agreed it is still okay for him to go on overnight leave due to the therapeutic benefit for him.	Feedback to medic involved in ordering to use correct form in future as would of prompted for date required and urgency. Discussion with nursing team and ward secretary of ensuring correct paperwork completed and urgency communicated effectively to pharmacy.	No further lessons identified	Closed
GHC81659	24/12/2024	23/12/2024	14:00	Forest of Dean Hospital	FoD Hosp-Woodland View Ward	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Other (unlisted)	No					patient arrived from acute trust without time critical medications	patient had some medication from home but unlabelled, medication ordered	patient transferred direct from ED family contacted and asked if there was medications at home that they could bring in. patient has dosette style box that she fills herself, has full capacity and no concerns around cognition. patient self administered medications prescribed from her own supply until pharmacy order delivered no missed dose	staff to be mindful when accepting patients direct from ED especially if needing non stock time critical meds SPCA updated on the situation as all admissions should come with TTO	Closed
GHC81698	24/12/2024	24/12/2024	13:30	ICT	Reablement Gloucester	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Atorvastatin	Yes	40MG	20MG	Oral		Double dose of medication-Atorvastatin was administered to Patient twice daily instead of once a day.	Contacted Patient's GP for advice and advised to continue medication administration. Also recommended calling 111 in case of any other reactions or symptoms. 30/12/24 MAR sheet amended to administer once a day only	Correct actions taken once error identified and MAR chart amended	Ensure review of instructions and dose for each medication on MAR chart	Closed
GHC81713	25/12/2024	25/12/2024	10:15	ICT	ICT Stroud SevernHealth DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Prescribing	Insulin glargine	Yes	18 units		Subcutaneous		Attended to administer patients insulin, when checking the drug chart I observed that the drug chart is not signed	Rang band 6 to check she was happy for me to administer, agreed that I would administer and then ring 111 to get the chart completed appropriately for ongoing administration.	Discussed with prescribing b7	Will remind staff of 5 rights when filling in medication records	Closed
GHC81743	25/12/2024	25/12/2024	19:30	Crisis Resolution Home Treatmt	CRHT Cots & Vale	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong / unclear dose or strength	Administration	Quetiapine	Yes	600mg XL	300mg XL	Oral	Oral	Cheltenham crisis team delivered two x 300mg medication tablets to Stroud crisis team for their patient who is residing with their mother overnight tonight. There was no explanation why two tablets were given to Stroud CRHTT. Medication was delivered to the patient at 7:30pm who informed me she takes two tablets at night not one tablet, and stated the medication would be 150mg tablets each. The patient took two tablets and on return to office at 7:45pm, my colleague reported each tablet was 300mg.	Immediately I rang on call doctor who checked the patients information and BNF which evidenced not being a significant risk with higher dose. Also reported side effects for patient to be aware of and to contact 999 or attend A&E should they experience these symptoms. I contacted the patient and explained situation, alongside stating side effects.	- Added Chelt CRHTT TM as additional reviewer, due to involvement of Chelt CRHTT staff in incident. - Review of clinical notes. - Request for additional information from clinicians involved. - Email sent to Stroud CRHTT to highlight lessons learnt as below.	- When medications need to be passed between CRHTT teams due to patient staying at alternative address, medications/prescription chart should be checked by registered nurse prior to handing to another team. - Receiving team to ensure a registered nurse checks medication/prescription. - Receiving team should not administer medication without a registered nurse having first checked medication/dosage against current prescription chart, and should not administer in absence of chart.	Closed
GHC81760	26/12/2024	26/12/2024	11:30	ICT	ICT Stroud BerkeleyVale DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong quantity	Administration	Other (unlisted)	No					I was replenishing a syringe driver and was supposed to add 20mg Morphine Sulfate and 30mg Midazolam. I was distracted during stock check as I was talking in depth to the patient as he was diagnosed with terminal cancer at just 35. I mistakenly added 30mg of both Morphine and Midazolam into the driver.	When I left the home I was documenting my notes on System One when I suddenly realised I should have added just 20mg Morphine and 30mg Midazolam. I phoned the patient as soon as I realised my mistake and apologised for the error. I returned to the house immediately and replenished the syringe driver with correct doses. I informed band 6 on duty. The patient was fine and completely understanding. The syringe driver had been in place for <30mins so new dose would have not gone through line. I replenished driver. Patient was fine on my departure.	No action required as visiting nurse realised mistake and corrected it quickly.	To double/triple check everything.	Closed
GHC81766	26/12/2024	25/12/2024	18:27	Charlton Lane Hospital	Charlton Lane-Mulberry Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	Low (minor harm, e.g. takes up to 1 month to rectify)	Wrong quantity	Administration	Paracetamol	Yes	1g	0.5mg	Oral	Oral	Patient had been given Paracetamol 1g on 24/12 at 23:18 1g 25/12/24 03:43 0.5mg 25/12/24 08:18 1g 25/12/24 13:07 1g 25/12/24 18:27 - overdose of paracetamol by 0.5mg in 24hour period outside of BNF limits	Email sent to nurse to make them aware, request a reflection; nurse required to do medication competency assessment on return to work Duty Dr informed to come and assess patient Patient NEWS taken Patient informed of overdose. Alternative pain medication prescribed.	Reflection received demonstrating learning Supervised drugs round completed Reflective discussion with supervisor	No further lessons identified	Closed
GHC81789	27/12/2024	26/12/2024	22:00	Forest of Dean Hospital	FoD Hosp-Woodland View Ward	Gloucestershire Hospitals NHS FT (GHNHSFT)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Ropinirole	Yes	noted twice administered on the same date		Oral	Oral	patient is taking Ropinirole daily at night 22:00 but noted it was already ticked off on 25/12 by the previous assigned nurse and another dose was already given on the same date just an hour and a half before patient was asking for the same medication last night 26/12 but assigned nurse is adamant to give as the boxed is already ticked off noted administered	tasked medical cover informed Band 6 in the morning NEWS 0 in the morning	review of systmone medication charts and discussion with patient and staff. medication had been given earlier than prescribed at patient request by late shift staff. night staff dispensed and signed for, as had already been administered recorded for next day. patient confirmed that she didnt take the second dose and nurse disposed of it. should have been marked in error.	request that medics change prescription time to mirror what time patient usually has this medication to prevent incident happing again if meds dispensed earlier than prescribed	Closed
GHC81800	27/12/2024	26/12/2024	10:20	ICT	ICT Chelt St Paul's DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Preparation by administering clinician(s)	Insulin human	No					HCA arrived at the property on 27/12 for daily insulin. Semglee and Humulin M3 pens on the table in the lounge. Hospital discharge summary and drug chart both state Humulin I and semglee. Grandaughter reports that her grandfather was on Humulin M3 prior to recent hospital admission. Medications had been changed during hospital admission. Insulins administered as prescribed at todays visit on yellow community insulin charts. When documenting todays visit on system one the care plan states Humulin I although on notes it is documented as Humulin M3 given at prior visit by RN.	Documentation checked and patient verified.BGL checked. Drug charts completed and both Semglee and Humulin I administered as prescribed.Photographs taken of discharge summary and hospital drug chart-items uploaded to the system for future reference.	Previous visit 26/12/2024 states humulin M3 administered. Discharge summary states humulin M3 stopped and humulin 1 commenced.	GP notes indicate repeat prescription for humulin M3 was stopped on 27-12-2024 New drug charts completed for humulin 1 insulin. No missed dose given	Closed
GHC81811	27/12/2024	23/12/2024	15:00	Wotton Lawn Hospital	Wotton Lawn-Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Wrong drug / medicine / item	Stock balance recording errors / discrepancies	Methylphenidate	No					Issued found during routine 3-monthly Controlled Drug check. Page74 of the stock CD book - running balance of methylphenidate 5mg tabs was 0, but a subsequent dose was signed as administered (unable to confirm what stock was used).	Reported to ward manager.			Being Reviewed
GHC81813	27/12/2024	27/12/2024	15:00	Integrated Urgent Care Service	IUCS OOH Service	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Controlled stationary (medication related)	None (no harm caused by the incident)	Missing controlled stationary	Controlled stationary							a number of blank prescriptions missing from the OOH medication cupboard at EJC since last check on Tuesday 24th December	Note found on OOH system to say the prescriptions had been taken to the OOH clinic at CGH as the Dr there was unable to use electronic prescribing	IUC service to implement a process for reception staff to check prescriptions at each site on each day the service is operational and to notify the Chief Pharmacist when more prescriptions are required and return the completed prescription log		Closed
GHC81817	27/12/2024	23/12/2024	15:00	Wotton Lawn Hospital	Wotton Lawn-Priory Ward	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Morphine	No					Errors found during routine 3-monthly Controlled Drug check. Multiple errors found in Patients Own CD Book: - Page 101 missing Zomorph capsules - Page 105 missing 'unknown substance' - Page 126 missing 3 bottles of methadone Above 3 errors all reported and DATIX'd 3 months ago at last check but CD books not corrected. Also, Page 139 - missing buprenorphine patch.	Reported to ward manager.			Being Reviewed
										Missing medication	Stock balance recording errors / discrepancies	Methadone	No									
										Missing medication	Stock balance recording errors / discrepancies	Buprenorphine	No									
GHC81819	27/12/2024	24/12/2024	10:12	ICT	ICT Glos Asp & Stbridge DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Administration	Clobetasone	Yes	Layer	Thin Layer	Topical	Topical	Upon completing MAR chart for Clobetasone 0.05% cream during a visit for wound care to a patient, it was identified that the MAR was not completed for the last application - which had been documented on Systm1 24.12.24.	Completed own documentation, reported to referral centre, and completed Datix. Photograph taken - on secure Trust phone, with patient consent - of document for confirmation if required upon reporting.	Notes read. Will discuss error with individual face to face to re-iterate importance of communication and clinical documentation. Overall care not effected.	To remind colleagues about the importance of effective clinical documentation. Overall care not effected.	Closed
GHC81859	28/12/2024	28/12/2024	16:50	ICT	ICT Stroud Cotswolds DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Stock balance recording errors / discrepancies	Other (unlisted)	No					Stock sheet error. 5 gylcoperronium were added to the chart even though they werent in the home. The home had evidence of this as they had a sticker of them being owed to them yesterday.	datix	staff reminded to check medication properly. there was no injury to the patient , just time wasted at the vissit for the nurse looking for the medication. Apologies made to the family	staff reminded to check medication properly. there was no injury to the patient , just time wasted at the vissit for the nurse looking for the medication. Apologies made to the family	Closed
GHC81902	29/12/2024	28/12/2024	18:00	ICT	ICT Cotswold South 2 DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Preparation by administering clinician(s)	Hydroxocobalamin	Yes	1mg/1ml		Intramuscular		Visited patient for routine B12 administration. Has a pink MAR chart written by a community nurse for the B12 administration 3 monthly. When checked patients identity, the date of birth has been recorded incorrectly, all other information was correct. MAR chart has been used for multiple administrations of B12 since October last year.	New MAR chart written and left in the property with the patient. Confirmed correct details with patient and on SystmOne	- Correct medication has been given to the patient. No medication error. - Date of birth on MAR chart had been incorrectly written by DN team, and subsequent doses were given and this error not noticed. - Staff should be checking patient personal details such as name, date of birth and NHS number at time of medication administration. This is something that all staff have been reminded about in team times.	- Staff have been reminded of correct safety procedures when administering medication at home, and safe and correct use of MAR sheets, as well as when writing them. Checking patient identifiable information should happen before administering any medications, regardless of how long the patient has been having it, and how well you know the patient.	Closed

GHC81929	30/12/2024	27/12/2024	11:00	ICT	ICT Cotswold North DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident involving controlled drug(s)	None (no harm caused by the incident)	Drug administration omitted / delayed	Administration	Buprenorphine	No					Arrived at patients home Friday to complete wound care. During visit patient explained that her Buprenorphine patch was not changed on Tuesday. Nurses change this weekly alongside wound care. Patient had not called in to referral centre prior to make aware.	Apologised for this. Checked this against the drug chart and the patch was dated from the 17/12/24. Nurse visiting was also present on Tuesday and confirmed not changed. Patch changed and drug chart completed (states weekly change on chart, no day specified). Have notified in Teams that change now due on Fridays. Documentation also changed on visits to Friday patch change.	Thank you for the datix. Patch not changed as planned and documented on patients appointment. Patient noted it was not changed but did not call DN team to make them aware prior to the appointment on Friday. Patch changed on the Friday and day changed to reflect the weekly change.	Nurse who visited Tuesday was present during the following visit, so apologised to the patient and aware to check patients notes/ appointment details.	Closed
GHC81937	30/12/2024	30/12/2024	11:00	ICT	ICT Cotswold South 2 DN	Pharmacy-community	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Missing medication	Ordering, collection or delivery	Other (unlisted)	No					2 week RN review of flaminal On arrival flaminal had not been issued despite request on 9/12/24 No escalation from staff to obtain flaminal	Conservative management had been in use since 9/12/24 Had trialled compression 20/12/24 but not tolerated Senior review 30/12/24 - full photos and management plan in place Dressings ordered	9th December Flaminol ordered - slough present to leg ulcer/ first line treatment. 11th December RNA visited - appointment highlighted to apply new treatment of flaminol when available as per guidance from Senior Community nurse. Used last of Aquacel AG however no evidence of further dressings ordered 13th December RNA visited - documented not followed care plan with using Aquacel AG dressing none in property so applied adaptic touch with no clinical rationale documented in notes. Did not follow care plan or treatment plan 16th -31st December further nursing team visited continued to follow previous application of dressings not following care plan Patient has declined bandaging to lower leg	Community nursing team not following care plan or treatment plan for patient. Wound has not deteriorated within this period of time however wound had not improved therefore potential delay in treatment Share this learning with team in Team Time and minute meeting to share with those who are not available to attend. Evidence of patient non adherent with specific dressings to wounds - completion of template done by senior community nurse	Closed
GHC81951	30/12/2024	30/12/2024	18:00	ICT	ICT Forest North DN	Gloucestershire Health and Care NHS FT (GHC)	Medication incidents	Medication incident not involving controlled drug(s)	None (no harm caused by the incident)	Drug chart errors - not signed, recording, other	Preparation by administering clinician(s)	Semaglutide	No					Care plan created for semaglutide, weekly administration 20/12, scheduled due date 27/12. Missed dose. Care plan not completed + no documentation of administration. Discussed with patient and she cannot remember if this has been given since she has been in the community. Unable to find drug chart in property. GP surgery closed during incident.	Discussed with late shift lead Escalated to GP via email and followed up with urgent phone call in the morning (31/12) to arrange drug chart to be written and confirm administration	31/12/24 CNL review. 20/12/24 Patient discharged from ward 6 GRH with new insulin prescription and community drug chart. Insulin administered. Care plans created for daily insulin and weekly insulin dose. 23/12/24 GP contacted to re-write drug charts however this was declined as GP wanted to review charts to prevent errors. Patient seen on the 30/12 for daily insulin care plans reviewed and noted that weekly insulin had been omitted. Patient could not recall if this had been administered and no drug chart could be found. 30/12 DN contacted GP for drug chart and informed of delay in insulin administration. 31/12 GP practice contacted again for follow up of insulin drug chart.	Thank you for your datix. All appropriate actions taken by DN on 30/12. Apology offered to patient for delay. Prescription chart delay probable cause confusion on the 23/12 as a care plan was created by team.	Closed