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21 December 2018

[redacted]
By email
[redacted]

Dear [redacted]

Request under the Freedom of Information Act 2000 (the "FOI Act")

We refer to your email of 23 November 2018 in which you requested information under the FOI Act from NHS Improvement. Since 1 April 2016, Monitor and the NHS Trust Development Authority have been operating as an integrated organisation known as NHS Improvement. For the purposes of this decision, NHS Improvement means Monitor and the TDA.

Your request

You made the following request:

"I would be grateful if you are able to provide me the following data from the National Reporting and Learning Service (NRLS).

Patient Safety Incidents reported 1st January 2017 – 31 December 2017

1. *Total number of medication incidents received where the medication process category = 'Prescribing'.*
2. *The number of prescribing incidents received from each healthcare sector e.g. acute, mental health, community nursing, general practice, community pharmacy etc.*
3. *The number of prescribing incidents by NRLS clinical outcome category e.g., death, severe harm, moderate harm, low harm, no harm.*
4. *The number of prescribing incidents by NRLS medication incident category e.g., omitted and delayed medicine, wrong dose, wrong medicine, wrong frequency, etc.*
5. *For prescribing incidents reported to have caused death, severe harm and moderate harm, the names of the medicines reported to be involved in these incidents, where this has been included in the report for each clinical outcome category*
6. *For prescribing incidents reported to have caused death and severe harm, the redacted description of the reported incident, causes, clinical outcome and corrective actions, where provided.*

I would be grateful if the information I have requested could be sent to my email address within the next 20 working days required by the FOI Act."

Decision

NHS Improvement holds the information you have requested and has decided to release all of the information that it holds.

Please refer to Annex A and B below for the data tables.

A search of the NRLS was carried out on 4 December 2018 of all incidents reported as occurring between 1 January 2017 and 31 December 2017, uploaded to the NRLS by 3 December 2018 where the Medication Error category is equal to 'Prescribing'. These incidents have been further broken down by healthcare sector, reported degree of harm and medication incident category as per parts 2-4 of your request. For incidents reported as causing 'moderate harm', 'severe harm' or 'death', the medicines reported to be involved are included. As noted in part 6 of your request, the Incident Level data for incidents reported as having caused 'Severe Harm' or 'Death' is included in Annex B.

About the NRLS

The information we hold is from the National Reporting and Learning System (NRLS). By way of background, some information about the NRLS may be helpful. The primary purpose of the NRLS is to enable learning from patient safety incidents occurring in the NHS. The NRLS was established in late 2003 as a largely voluntary scheme for reporting patient safety incidents, and therefore it does not provide the definitive number of patient safety incidents occurring in the NHS.

All NHS organisations in England and Wales have been able to report to the system since 2005. In April 2010, it became mandatory for NHS organisations to report all patient safety incidents which result in severe harm or death. All patient safety incident reports submitted to the NRLS categorised as resulting in severe harm or death are individually reviewed by clinicians to make sure that we learn as much as we can from these incidents, and, if appropriate, act at a national level.

The NRLS is a dynamic reporting system, and the number of incidents reported as occurring at any point in time may increase as more incidents are reported. Experience in other industries has shown that as an organisation's reporting culture matures, staff become more likely to report incidents. Therefore, an increase in incident reporting should not be taken as an indication of worsening of patient safety, but rather as an increasing level of awareness of safety issues amongst healthcare professionals and a more open and transparent culture across the organisation.

Review rights

If you consider that your request for information has not been properly handled or if you are otherwise dissatisfied with the outcome of your request, you can try to resolve this informally with the person who dealt with your request. If you remain dissatisfied, you may seek an internal review within NHS Improvement of the issue or the decision. A senior member of NHS Improvement's staff, who has not previously been involved with your request, will undertake that review.

If you are dissatisfied with the outcome of any internal review, you may complain to the Information Commissioner for a decision on whether your request for information has been dealt with in accordance with the FOI Act.

A request for an internal review should be submitted in writing to FOI Request Reviews, NHS Improvement, Wellington House, 133-155 Waterloo Road, London SE1 8UG or by email to nhsi.foi@nhs.net.

Publication

Please note that this letter will shortly be published on our website. This is because information disclosed in accordance with the FOI Act is disclosed to the public at large. We will, of course, remove your personal information (e.g. your name and contact details) from the version of the letter published on our website to protect your personal information from general disclosure.

Yours sincerely,

NHS Improvement

Annex A

Table 1: Total number of Medication Prescribing incidents

Base: Incidents reported to the NRLS between 1st Jan 2017 and 31st Dec 2017

Medication Process Category	2017
Prescribing	55,536

Table 2: Total number of Medication Prescribing incidents broken down by Care Setting of Occurrence

Base: Incidents reported to the NRLS between 1st Jan 2017 and 31st Dec 2017

Care Setting of Occurrence	Number of incidents
Acute / general hospital	47,774
Ambulance service	18
Community and general dental service	8
Community nursing, medical and therapy service (incl. community hospital)	2,476
Community pharmacy	444
General practice	1,379
Learning disabilities service	89
Mental health service	3,348
Total	55,536

Table 3: Total number of Medication Prescribing incidents broken down by Reported Degree of Harm

Base: Incidents reported to the NRLS between 1st Jan 2017 and 31st Dec 2017

Reported Degree of harm	2017
No Harm	49,705
Low	5,107
Moderate	635
Severe	59
Death	30
Total	55,536

Table 4: Total number of Medication Prescribing incidents broken down by Medication Error Category

Base: Incidents reported to the NRLS between 1st Jan 2017 and 31st Dec 2017

Medication Error Category	2017
Adverse drug reaction (when used as intended)	323
Contra-indication to the use of the medicine in relation to drugs or conditions	2,818
Mismatching between patient and medicine	2,492
Omitted medicine / ingredient	10,860
Patient allergic to treatment	1,703
Wrong / omitted / passed expiry date	99
Wrong / omitted patient information leaflet	56
Wrong / omitted verbal patient directions	158
Wrong / transposed / omitted medicine label	265
Wrong / unclear dose or strength	11,027
Wrong drug / medicine	4,408
Wrong formulation	1,069
Wrong frequency	4,216
Wrong method of preparation / supply	650
Wrong quantity	2,113
Wrong route	693
Wrong storage	81
Other	11,615
Unknown	890
Total	55,536

Table 5: Total number of Medication Prescribing incidents with a reported Degree of harm as - 'Moderate', 'Severe' or 'Death' - broken down by Approved Name (Drug 1)
Base: Incidents reported to the NRLS between 1st Jan 2017 and 31st Dec 2017

Approved Name (Drug 1)	2017
<Missing>	66
0.45% sodium chloride	1
10 Units Humulin M3	1
acarbose	1
Aciclovir	1
aciclovir	3
Aciclovir 250mg/10ml Injection	1
Actrapid	1
actrapid	1
ACTRAPID (10ml Vial) Insulin Injection	1
Actrapid Insulin	2
Actrapid Insulin Infusion	1
acyclovor	1
Adcal-D3	1
adrenaline	1
advate	1
alemtuzumab	1
Alfacalcidol	1
all	1
Alteplase	1
amikacin	1
AMILORIDE	1
amiodarone	1
amisulpride	1
AMITRIPTYLINE	1
AMLODIPINE	1
amlodipine	1
Amlodipine 5mg Tablets	1
AMLODIPINE BESILATE	1
Amlodopine, Doxazosin, Metformin	1
Amoxacillin	1
AMOXICILLIN	4
Amoxicillin	1
Amoxycillin	1
anthracycline	1
antibiotic	1
ANTICOAG	1
anti-convulsant	1
Anti-retrovirals	1
antithrombin III	1
Apixaban	5

Approved Name (Drug 1)	2017
apixaban	4
Aripiprazole	2
asasantin retard	1
Aspirin	2
aspirin	3
Atorvastatin	1
Augmentin	1
azathioprine	1
Baclofen	1
baclofen	2
bendroflumethiazide	2
benzlpenicillin	1
beta blocker	1
bisoprolol	8
BISOPROLOL FUMARATE	1
Bisoprolol, Flecinide	1
Bumetanide	1
bumetanide	1
buprenorphine	1
candesartan	1
Capecitabine	1
carbamazepine	1
cefalexin	1
Ceftazidime	1
ceftriaxone	1
CHLORDIAZEPOXIDE	2
chlordiazepoxide	1
Chlordiazepoxide Hydrochloride	1
chlorpromazine aripiprazole	1
ciclosporin	1
CIPROFLOXACIN	2
Ciprofloxacin	1
cisplatin	1
citalopram	1
CLARITHROMYCIN	2
Clarithromycin	3
clarithromycin	1
Clbazam	1
Clexane	4
clexane	1
Clexane (enoxaparin)	1
clonazepam	1
CLOPIDOGREL	2
clopidogrel	3
clopidrogel	2

Approved Name (Drug 1)	2017
Clozapine	1
clozapine	3
Clozapine (Clozaril, Denzapine)	1
CMW 1 Gentamicin	1
Co-Amoxiclav	3
Co-amoxiclav	1
co-amoxiclav	4
Co-amoxiclav 1000/200(1.2g) Injection Amoxicil	1
co-beneldopa	2
co-careldopa	5
cocodamol	1
co-codamol	1
CO-TRIMOXAZOLE	1
Curosurf	1
cyclizine	1
cyclosporin	1
daltaparin	1
DALTEPARIN	1
Dalteparin	6
dalteparin	15
Degludec	1
deltaparin	1
DESMOPRESSIN	2
Desmopressin	1
DEXAMETHASONE	1
Dexamethasone	1
dexamethasone	5
dexamphetasone	1
dextrose	1
dextrose and actrapid	1
Diamorphine	1
diamorphine	1
Diamorphine Hydrochloride	1
Dianette	1
DIAZEPAM	1
diclofenac	2
Digoxin	1
digoxin	1
diltiazem	1
disodium pamidronate	1
Dithranol	1
DOCETAXEL	1
doxycycline	1
Drug name unknown	2
Drug not stated or more than one drug listed	2

Approved Name (Drug 1)	2017
edoxaban	2
Elvanse 20mgs	1
enalapril	1
ENOXAPARIN	2
Enoxaparin	3
enoxaparin	15
enoxparin	1
fentanyl	2
ferrous sulphate	1
fidaxomicin	1
FLUCLOXACILLIN	1
flucloxacillin	3
Flucloxacillin 250mg Capsules	1
Fluconazole	1
Flucoxacillin	1
fluorometholone	1
Fluorouracil	1
Fluoxetine	1
Fluoxetine, 20mg, Capsules	1
Flupentixol Decanoate	1
fluticasone	1
fondaparinux	1
frusomide	1
furosemide	3
FUROSEMIDE (FRUSEMIDE)	1
FUROSEMIDE 40mg TABLETS	1
Furosemide, Isbesartan, Acenecoumarol, Rivaroxaban	1
g	1
GABAPENTIN	1
gabapentin	1
Galantamine	1
ganfort eye drops	1
Gemcitabine and Capecitabine	1
GENTAMICIN	2
Gentamicin	2
gentamicin	8
Gentamycin	1
gliclazide	1
glimepride	1
hartmanns	1
Heparin	3
heparin	5
Humalog insulin	1
Humalog Kwikpen insulin	1
HUMILIN M3 INSULIN	1

Approved Name (Drug 1)	2017
Humulin	1
HYDROCORTISONE	1
Hydrocortisone	1
hydrocortisone	3
hydroxyurea	1
hydroxyzine	1
hyloforte	1
imipramine	1
indapamide	1
Infections	2
INSULIN	2
Insulin	4
insulin	2
Insulin Humalin M3	1
Insulin Humalog	1
Insulin Humalog Kwikpen	1
Insulin Humulin I	1
Insulin Insulatard Innolet	1
Insulin lispro (Humalog) [Recombinant human insulin analogueshort acting]	1
Insulins	1
insulins	39
INTERMEDIATE- AND LONG-ACTING INSULINS (OTHERS)	2
IPC	1
Irbesartan	1
Irinotecan	1
Iron sucrose	1
Isosorbide Mononitrate	2
Itraconazole / Sporonox	1
iv fluids	2
Iv Insulin Infusion	1
ketamine	1
Ketorolac	1
ketorolac	1
labetalol	1
labetolol	1
lactulose	2
lamotrigine	2
Lamotrigine(Lamictal) 100mg Dispersible Tablets	1
lansoprazole	1
Lantus Insulin	1
LEVETIRACETAM	1
Levetiracetam	1
levetiracetam	1
Levonelle and Topiramate	1

Approved Name (Drug 1)	2017
Levothyroxine	1
LEVOTHYROXINE (THYROXINE)	1
LEVOTHYROXINE SODIUM	1
Librium 2 25MG pills	1
Lithium	1
lithium	2
Lithium Carbonate	1
Lorazepam	3
lorazepam	4
memantine	1
MEROPENEM	1
Meropenem	1
meropenem	2
mesalazine	1
METHADONE	1
methadone	4
Methotrexate	1
methotrexate	1
methylphenidate	1
Metolazone	1
Metoprolol	1
metoprolol	1
metronidazole	1
METRONIDAZOLE (ZIDOVAL) Vaginal Gel	1
Midazolam	1
Midazolam, Haloperidol and Glycopyrronium	1
Mirtazapine	2
mirtazapine	1
Morphine	1
morphine	8
Morphine 10mgs	1
MORPHINE SULPHATE	2
morphine sulphate	2
Morphine sulphate MST	1
movi -prep	1
Movicol	1
MST 30mg	1
Multiple	1
N/A	1
n/a	1
NA	1
naproxen	2
NIFEDIPINE	1
Nitrofurantoin	2
nitrofurantoin	1

Approved Name (Drug 1)	2017
No	1
no	1
No Drug Given	22
noac	1
NONE	2
None	3
none	1
Not Applicable	1
not applicable	1
Not Stated/Unknown	1
novomix 30	1
OESTROGENS, CONJUGATED	1
Olanzapine	1
olanzapine	1
OMEPRAZOLE	1
omeprazole	1
Oramorph	1
oramorph	1
Oramorph 10mg In 5ml	1
Oramorph Concentrated Oral Solution 20mg/Ml	1
Other	1
Other (not listed) - enter details below	11
Oxaliplatin	1
oxycodone	1
oxygen*	2
paclitaxel	1
Pantoprazole	1
Paracetamol	2
paracetamol	1
Parenteral Nutrition	1
pemetrexed	1
PENICILLIN	1
penicillin	1
Penicillin V	1
perindopril	1
Phenobarbital	1
Phenytoin	2
Phosphate-Sandoz	1
PIPERACILLIN 4g and TAZOBACTAM 500mg	1
Pivmecillinam	1
PREDNISOLONE	2
Prednisolone	1
prednisolone	2
Prednisolone (Predsol)	1
Pregabalin	1

Approved Name (Drug 1)	2017
pregabalin	2
Premarin	1
Prempak	1
Priadel	1
Priadel (Lithium Carbonate)	1
Procyclidine	2
promethazine	1
Prophylactic Enoxaparin	1
PROPRANOLOL	1
Propranolol	3
PROSCAR	1
Pyridostigmine	1
QVAR 100 inhaler, Clenil modulite 100 mcg inhaler	1
RAMIPRIL	1
Ramipril	1
ramipril	1
Ranitidine	1
Repevax	1
RISPERIDONE	2
Risperidone	1
risperidone	1
RIVAROXABAN	3
Rivaroxaban	4
rivaroxaban	1
Rivaroxaban and Enoxaparin	1
rivaroxiban	1
ropinirole	1
rot	1
rotigotine	1
Salbutamol	1
salbutamol	1
sertraline	1
Sevelamer	1
Shortec (oxycodone)	1
Sodium fusidate 2% ointment	1
Sodium Valproate	2
Sodium valproate	1
sodium valproate	2
steroids	1
tacrolimus	1
tamoxifen	1
tamsulosin	1
Tazocin	3
teicoplanin	1
Terlipressin	1

Approved Name (Drug 1)	2017
theophyllin	1
thyroxine	1
Ticagrelor	1
TINZAPARIN	4
Tinzaparin	1
tinzaparin	6
tiotropium	1
Toujeo	1
tramadol	1
Tramadol Tablets	1
Tranexamic Acid	1
tranexamic acid	1
Tresiba	1
triamcinolone	1
trimethoprim oral solution	1
TRIMOVATE	1
UNKNOWN	1
Unknown	6
unknown	1
unsure	1
valproic acid	2
vancomycin	3
Varicella Zoster Vaccine	1
Various	1
VENLAFAXINE	1
Venlafaxine	1
Venlafaxine (Efexor, Efexor Xl,)	1
venlafaxine, quetiapine, aripiprazole	1
warfain	1
WARFARIN	4
Warfarin	3
warfarin	8
z	1
zomorph	1
Zopiclone	1
Total	**724**

Annex B

Raw Data from Medication - Prescribing incidents with a reported Degree of Harm: 'Severe Harm' or 'Death'

Number of incidents: 89

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
[Healthcare Professional] visit was requested initially to administer a stat dose because the member of staff taking the call thought that they could attend quicker than we could at that time . I did visit before the [Healthcare Professional] and identified that , although stat doses were prescribed and medication in the house the syringe driver had not been authorized . As the night service had been called out to administer midazolam it is likely that a syringe driver may be needed over the weekend . I spoke to [Healthcare Professional] before [Healthcare Professional] left the surgery and asked that she[Healthcare Professional] prescribe the syringe driver . When I visited the next day I discovered that [Healthcare Professional] had prescribed the medication in the same doses as the stat doses , i.e . 2.5mg Diamorphine over 24hrs . Clearly this would be inadequate to control pain . During this visit I had to administer 2.5mg Diamorphine stat . This was effective and I contacted 111 to visit and rewrite the doses at [Time] . I explained the situation to the call handler . 111 informed me that [Location A] GP service would contact me within 30 mins . Almost immediately [Location B] GP Service contacted me to say that they would not visit a [Location A] patient and that I would have to ring 111 again to rerequest [Location A] GPs . I did this immediately and was told that I would receive a call back within 30 minutes . After 1 hour I phoned back to be told that there was no record of my previous call and I had to give the details again and was told that I would receive a call back within 30 minutes . I had to phone another twice and give the numbers for the Evening Service . At approx . [Time] my colleague			Severe

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
spoke to a [Healthcare Professional] who was rude but did give a mobile number and asked that I contact her directly to discuss the matter . At [Time] I spoke to this [Healthcare Professional] who was rude and literally just said to me ' I'm sending a GP out ' before I could introduce myself . At [Time] a [Healthcare Professional] visited and refused to change the medication doses because they were all ready prescribed , despite the family explaining the situation . The night staff were required to visit twice to administer stat doses of Diamporphine and Midazolam and I gave the same late morning. I spoke to the [Healthcare Professional] at [Healthcare Provider] who was unable to visit and prescribe because the patient is not known to them . At [Time] I called 111 and explained the situation to the call handler and requested a GP visit . [call handler] explained that they were very busy but that [call handler] would put him for an urgent call back . At approx . [Time] a GP called me to ask about the situation and called me back a short time later to say that she was going to send a GP out to see the patient . .			
[Healthcare Professional] at hospital prescribed mesalazine . Patient read information leaflet which stated that this medication should not be taken if any adverse reaction to aspirin - patient recalled anaphylaxis after aspirin in the past but had not been asked by the [Healthcare Professional] .			Severe
Patient on Warfarin pre - operatively . Warfarin discontinued for surgery [Date] . Intention was to give Enoxaparin cover post - op until Warfarin was back to established therapeutic level . However , due to patient bleeding , Enoxaparin was withheld after [x] days . The Warfarin was delayed until bleeding stopped and patient stable , Warfarin was recommenced with no Enoxaparin cover until therapeutic range achieved . Patient arrested and died . Post mortem identified cause of death: 1 Pulmonary Embolism 2 Venous Thrombosis .	Recall requested and approved by Trust Commissioners .	72 hour report due [Date] 60 Days RCA report due to STEIS on [Date] Clinical Risk committee presentation [Month, year]. RCA [Number] - Recalled request approved by CCG . Linked to incident noo . [Number].	Death

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
Renal dialysis patient with background of [mutiple additional serious health conditions that in combination may be person identifiable]. On ITU [patient] was started on high dose therapeutic fragmin on [Date] along with existing aspirin and clopidogrel . [patient] was discharged to the ward [Number] subsequently . On the [Date] fragmin was stopped on the consultant ward round because of rising PT and APTT and bruises and factor xa level then performed . Xa level came back as high , 1.5 . Approximately at the time of xa level receipt the patient had spontaneous bleeding into [gender] right upper arm with subsequent compartment syndrome requiring fasciotomy under general anaesthetic with subsequent return to ITU for monitoring and support . Earlier factor xa levels (after fragmin commencement) and initial dose adjustment for a dialysis patient may have reduced the chances of this spontaneous bleed in a patient already on dual antiplatelet . .			Severe
Patient admitted with embolic right critical limb ischaemia . Had below knee amputation on [Date] . Stepped down to ward . VTE prophylaxis omitted in error . Patient died from possible pulmonary embolism on [Date] . Given thrombolysis on CPR . Not yet confirmed that patient died as reult of this omission - post mortem examination will be done . Ommission will be discussed with the patient wife when discussing need for post mortem exam . .			Death
I went to take blood from the patient and found him to be vague and sweaty +++ . .	patient observed fr potential side effects .	medicine management competencies completed by individuals involved .	Severe

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
Patient admitted with an acute kidney injury after ten days of poor fluid and dietary intake at home , on nephrotoxic medication . On admission , potassium 6.1 and [Healthcare Professional] prescribed fifty units of actrapid in 50ml dextrose over 30 minutes . This was given by the [Healthcare Professional] as prescribed . Patient became unwell and hypoglycaemic . **please note , there was no field for ' hypoglycaemia' so I ticked ' kidney'** correct dose is 10 units , see [Location] - central guidelines [Location].	patient was monitored and observed for effects of excessive insulin . patient des not appear to have suffered long term adverse effect of this .	staff made aware of the need to check prescption sheets prior to medication administration . nursing staff involved completed medicine management competencies following this incident .	Severe
A patient on the ward who has been very unwell has had 3 drug related errors : 1) Antibiotics prescribed on [Date] at [Time] and nurse informed , however not ordered from pharmacy until next day and then not given until [Time] on [Date] 2) Patient who had an AKI stage 1 was prescribed continuous IVF replacement , documented in notes - however does not appear to have been given overnight (no signature on [System]) 3) Patient had low Mg levels , and prescribed oral replacement , however not given (number 2) on [System] all weekend , even though pharmacist found some in stock on Monday morning . . The patient has since deteriorated and her renal function progressed . She is now in multi - organ failure and septic shock . These issues may have exacerbated her condition . .			Severe
Incident detected when medical records not previously available examined for coroners report . [Healthcare Professional] charted enoxaparin 20mg subcutaneously in patient who was admitted with subdural haematoma after fall and that was not present on previous [Date] CT head scan . This was administered for next three weeks before patient discharged on [Date] and anticoagulation stopped . Patient readmitted next day and died on [Date] . Subdural had increased in size on CT head scan done [Date] . .	[Date][initials]Appropriate recipients have received details of this incident , so once all the relevant information has been obtained and if there remains a concern that there has been an omission of care by someone that has caused harm to this		Death

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
	patient then they will need to raise an adult protection alert . Please contact the safeguarding team to discuss further if required . [Name]		
Communication received about recent events . I discussed the recent events with staff nurse from the [place] and reviewed patient in Critical care unit at [Hospital Name] . Patient is admitted with sepsis possibly secondary to chest infection and intestinal pseudo - obstruction . . Staff from [Healthcare Provider] said that patient has been doing well in his physical health and there were no significant concerns in the preceding months . He had episode of vomiting and diarrhoea when there was outbreak of D&V just before [date]. There was no major concerns about his constipation and he has been on Laxido . They had new patients admitted and in our patient had been keeping to himself and staying in his room over the last [x] weeks . [patient] has not been smoking as much as [patient] usual over the last couple of weeks . [patient] started to complain about abdominal pain last week and staff tried to book an appointment with the GP however later on he said that [patient] was fine . They did a set of physical observations on Sunday which were normal . [patient] did not look that well and they tried making an appointment on Monday and when the staff nurse was on duty on Wednesday [Date] , patient looked unwell and [healthcare professional] arranged an urgent appointment with the GP . [patient] had developed abdominal distention and his trousers were not fitting him . The GP did an urgent set of bloods and made an urgent 2 weeks referral . On [Date] , [pateint] looked quite poorly and they had to contact 111 and [patient] was subsequently taken to hospital . .	Ongoing investigation .	Ongoing investigation .	Severe

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
Wrong insulin prescribed , this new patient on [Date] supplied the practice with wrong medication details from an old prescription . Patient started having trouble with their blood monitoring . On [Date] Pharmacy alerted the practice that the wrong insulin had been prescribed . This was discussed with the [Healthcare Professional] who ensured the practice correct the prescription . The patient was reviewed again by the [Healthcare Professional] . .			Severe
[Healthcare Professional A] informed us via letter that dose of mirtzapine was 50mg . [Healthcare Professional B] queried this before prescribing and dose was corrected to 15mg - typo error . .			Severe
[healthcare professional] asked to deal with morphine script that needed signing on [Date] . In doing so [healthcare professional] noted that it was for the oramorph concentrated solution which [patient] was having regularly 3 times a month in the last 5 months . On looking further [healthcare professional] established that [patient] had been over prescribed this medication from [Date] to present . .	Upon discovery [healthcare professional] discussed with [healthcare professional B] and sought advice from the pain specialist. [patient] was informed by telephone and a reducing prescription was formulated using the advice of [healthcare professional B] and the pain specialist . Prescribing [healthcare professional C, pain specialist] informed.	[patient] required a change in prescription to a sugar - free formulation . This formulation is at a different strength to the original prescribed medication . .	Death

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
Incident reported 3 times 1) Medication prescribing error . I will use a calculator to calculate the dose . Explained the Oramorph dose was x10 the expected . This was a prescribing and administration error . But child was still symptomatic 3 hrs in pain with no respiratory arrest after administration . His mother and maternal grandparents were concerned he was still in pain and requested for further analgesia . It was at this point that the prescribing error was identified and a further stat dose was not given despite the child been in pain . This was an expected death and [child] was for palliative care . Form 2 [Number]: the patient was in pain the [Healthcare Professional A] asked the [Healthcare Professional B] to prescribe another dose of morphine sulphate . when I checked the dose in the bnf it was 10 x the volume stated . Discussed with the [Healthcare Professional C] and she was happy to give it as she felt it was a palliative dose. as we had no evidence of this another dose was not given a previous dose at [Time] was however given. [Healthcare Professional] informed. nurse Practitioner informed consultant aware Form 3 [Number]: PATIENT PASSED AWAY Copied from revalidation box: the patient passed away . DNR insitu , oxygen administered now response . death [Time] .			Severe

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
A [Age] [gender] patient was transferred to the Surgical Assessment Unit at the [Hospital A] from the Emergency Department at [Hospital B] on [Date] . The investigation will aim to identify whether there were any care or service delivery issues in the treatment of the patient sepsis prior to his transfer . .	[Date] [Job Title] - Further updates requested from Handler , [Healthcare Professional A] , [Healthcare Professional B] , [Healthcare Professional C] . [Date] Patient Safety Team - This should be for Urgent Care . This has been discussed with the Trust [Healthcare Professional] . [Date] weekly patient safety summit - Group agreed to escalate as serious incident . [Healthcare Professional] to undertake Duty of Candour . [Date] Surgery Risk Meeting - Reviewed , this is an ongoing SI investigation . [Date] Surgery Risk Meeting - Reviewed , this is an ongoing SI investigation in Urgent Care . [Date] Patient Safety Team - RCA submitted to CCG . [Date] Patient Safety Team - RCA retracted from the CCG by the	Thank you for reporting this incident on [Date] . This was investigated by Root Cause Analysis , the findings of the report are as follows:- . Root Cause of incident - Poor communication and poor recording of the plan of care , further monitoring and follow up arrangements required for the patient resulted in an unsafe discharge from A&E during the patients first care episode . Failure to follow the Sepsis Six care processes on re - admission resulted in sub - optimal care and contributed to the patients deterioration . . Recommendations and action plan:- . Outlying patients who require consultant review must be identified by the shift coordinator and discussed with the consultant each morning . Discharge letters are to be checked and signed prior to posting by a senior doctor . For patients who reside in residential or nursing care homes then a discharge letter must be provided . [healthcare professionals] to	Death

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
	Patient Safety Lead following discussion with the [Job Title] and the CCG . Further information requested from the Emergency Department [Healthcare Professional] before the RCA can be returned . [Date] Surgery Risk Meeting - Risk Facilitator advised the meeting that the RCA report had been submitted to the CCG , however since then the [Healthcare Professional] (Urgent Care) and [Healthcare Professional] (Urgent Care) have contacted the CCG to say that the submitted report is being re - reviewed and that a revised version will be submitted to the CCG in due course . The Report is not to be shared to anyone at this time because it is now being revised . [Date] Patient Safety Administrator - Report re - submitted to	provide training updates for staff in team meetings and also place information on a display board in the A&E staff area . [Healthcare Professional] to schedule training with A&E staff in the use of pain indication / distress tools for patients with learning disabilities . A debrief to be arranged with all staff involved to ensure an understanding that relevant details of care given including ongoing monitoring instructions , plans of care and clinical rationale for treatment / withholding treatment are clearly documented in the health records ; this includes documenting what actions have been taken following diagnostic results . All staff to be retrained in the recording of NEWS and the use of the Sepsis Six assessment tool . All staff to be retrained in the recording of NEWS . SBAR handover / communication tool to be devised for the transfer of surgical patients .	

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
	CCG and root cause , actions etc updated as a result of this . [Date] Surgery Risk Meeting - this SI has been resubmitted to the CCG . awaiting CCG feedback . [Date] Urgent care Clinical Unit Meeting - RCA findings have been discussed at this meeting and shared in the most recent newsletter . [Date] [Healthcare Professional] - Notification received from Clinical Commissioning Group . Root Cause Analysis report Kept Open for additional work . Author notified [Date] . Updated report requested back by [Date] . Will require re - review and discussion by Division at Quality and Governance Risk meeting once closed by Clinical Commissioning Group due to the changes and updates being requested to	Audit of health records to be carried out to identify compliance with appropriately documented communication between nurses and families . Regular spot check audits of compliance with the Trust sepsis policy to ensure learning and understanding has been embedded . [healthcare professionals] within Urgent Care to be identified . [healthcare professionals] to provide training to staff regarding the appropriate use of the [local] documentation which should be commenced as early as possible following the patients arrival in the A&E department. Spot check audits to be carried out to identify the level of compliance with patients receiving their regular medicine regimens whilst in hospital . Effective emergency care policy to be followed which will outline the escalation process and any incidents to be reported on Datix as appropriate . Spot check audit of documentation	

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
	lessons learned and recommendations and actions sections . [Date] Surgery Risk Meeting - the Risk Facilitator advised the meeting that the RCA was kept open by the CCG for additional work . [Date] Urgent care Clinical Unit meeting - RCA presented [Date] [Healthcare Professional] - learning from incident to be discussed by Clinical Unit once has been updated and closed by CCG . [Date] [Healthcare Professional] - resubmitted updated report to CCG . [Date] Patient Safety Facilitator - Datix updated with changes to Recommendations and Actions . [Date] [Healthcare Professional] - Notification received from Clinical Commissioning Group [Date] . Serious Incident closed . Final Root	within the Emergency Department to ensure that all clinical decisions have been signed for in accordance with General Medical Council guidance A`Good Medical Practice (2013) . Feedback of relevant learning from this investigation to be provided to [local system] in relation to the monitoring of observations during the transfer of the patient between acute hospital sites . [Healthcare professional] to receive a copy of this RCA to enable them to provide targeted training to A&E staff. Communication to all nursing and medical staff within the A&E department stressing the importance of clearly documenting all clinical decisions and appropriate pain assessment documentation . .	

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
	Cause Analysis report uploaded to Datix and Investigator and Division notified . Duty of Candour loop needs to be closed and changes to outcomes and lessons etc . , shared with the Division . (Changes occurred since report was last shared , so the additional and new information now needs to be communicated .) [Date] [Healthcare Professional] - Emailed [Healthcare Professional] to ask if Duty of Candour loop has been closed and if report shared or scheduled for discussion at Divisional level . [Date] [Healthcare Professional] - Emailed [Healthcare Professional] to ask if report and learning was shared with [relative] on [Date] when was scheduled to meet . Notification was received from her earlier this date re all outstanding reports		

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
	being scheduled for Divisional review [Date] . [Healthcare Professional] confirmed same day report was shared with patient brother . [Date] Surgery Risk Meeting - RCA reviewed and learning shared . The nursing home should have sent the patient with a this is me passport . Diagnostics Anaesthetics and Surgery Governance will advise the [Healthcare Professional] of this incident . All actions are to be che .		

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
Sequence of multiple different acute illnesses and different interventions over short period that in combination may be person identifiable] Stroke a likely consequence of being off Rivaroxaban too long : see Anti - coagulation Guidelines on Intranet .			Severe
Patient was admitted initially end of [Month] with UTI . Risk assessment only step 4 completed which stated haematuria . No MTP of CTP prescribed during this admission . Patient re - admitted [x] days later with chest pain / URTI & YTI . Poor completion of RA - step 2 only . CTP not prescribed for first [x] days post admission - also dose omission but no reason documented . This patient was re - admitted [x] months post discharge with bilateral PE (non - fatal) .	This is more relation to prescribing / risk assessment so transferred to Dr to review . .	. This issue has been discussed with the [Job Title] and all clinicians have been reminded about timely testing and reporting of results and ensuring appropriate & timely treatment to prevent recurrence .	Severe
Patient admitted after a fall . Right sided chest pain , hypoxic on air . Due to suspicion of PE , therapeutic Enoxapain was given . It was followed by CT which showed rib fracture and massive haemothorax . Chest drain inserted in ICU and patient transferred to surgical ward where she deteriorated and died . .			Severe

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
Patient admitted morning of [Date] . Shortness of breath and leg and abdomen swelling . .[...] , including DVT prophylaxis not completed , no thromboprophylaxis prescribed . . Diagnosis of Heartfailure and and acute bronchitis . subsequent hyponatraemia secondary to diuretics . [Date] moved to [Ward] [Date] Drug history obtained by ward pharmacist (lack of throboprophlaxis not identified) [Date] [...] CTPA [Date] PE confirmed and anticoagulation started . Patient passed away over weekend . (Reviewed by [Job Title] and deemed reportable as a death) .	Serious incident review undertaken linked to concern submitted by patients family . .	when patient is jointly managed between medicine and orthopaedics then both should review prior to discharge . Medication should be gone through with patient and family on discharge .	Death
Elderly [gender] patient admitted with emergency surgery condition had oral anticoagulation appropriately reversed on admission to facillitate life saving surgery . There were some post op complications which necessitated not re starting anticoagulation for [number of] days approx post op . However , once surgically fit , oral anticoagulation was not re started for a further [number of] days , despite daily clinical review , and patient was maintainied on prohylactic tinzaparian only . Oral anticoagulation was subsequently re started [number of] days later , following further advice , but there was a [number of] day (approx) period prior to this when anticoagulation could have been re started but was not . Patient was discharged in fair health on warfarin , but readmitted shortly after with a stroke , which is presumed to have been embolic in nature . It is possible that the [number of] day period without full anticoagulation may have contributed to this . .	. SIARC .		Severe
[Age, Gender] admitted on [Date] with an AECOPD and type 2 respiratory failure . COPD admission bundle not used . Although it was documented clearly in the notes that the patients target saturation range should be kept at 88-92% , oxygen was not prescribed . The patient was given 3l of uncontrolled oxygen throughout the night with sats recorded between [>92%] with no	Please see 72 hour report attached in documents for further details .	Please see 72 hour report attached in documents for further details .	Death

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
attempt to down titrate her oxygen . On my arrival at [Time] on [Date] the patient was obtunded and in extremis . A blood gas was taken immediately which showed pH [<7.4] , PaCO [>2] . NIV outreach alerted and NIV was started immediately on the patient . .			
Haemodialysis patient admitted with pleuritic chest pain and found on CTPA to have PE . Commenced and discharged on apixaban (FP10) which is contraindicated in end stage renal failure . Readmitted on [Date] with headache confusion , epistaxis and developed reduced GCS . Required Beriplex to help reduce risk of bleeding from needed LP . Found later to have subarachnoid haemorrhage not amenable for neurosurgical intervention . Patient died [Date] . .			Death
Patient was transferred from [Location] after being admitted with community acquired pneumonia on background of COPD and was stable from medical perspective . He was awaiting discharge planning and transferred to [Unit Name] between [Date] (not entirely clear) . He started deteriorating (high resp rates) on [Date] and there were no medical concerns raised . On [Date] , he deteriorated further , with deterioration in conscious state . He was diagnosed with a hospital acquired pneumonia on [Date] . He was over oxygenated for 24 hours prior to that in [Unit Name] despite having target saturations of 88-92% recorded on top of observations chart (no e - obs then)and went into type 2 respiratory failure . .	See 72 hour report .	See 72 hour report .	Death
Patient became unwell , possible cerebral infarction . . On reviewing notes , warfarin has not been given since admission . Several entry in both medical and nursing notes indicate that warfarin should be restarted but no action appears to have been taken . .	Logged as SI . .		Death

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
This patient was admitted to [Ward] following a fall and head injury in [Date] . Patient was anticoagulated on warfarin . A CT head was ordered and reported as ' Generalised involutional change . No intracranial haemorrhage ' . Warfarin was continued . This patient represented [time] weeks later in [Date] with slurred speech , left facial droop and left arm weakness . [number]mm subdural seen on CT scan noting that there was a potential small haematoma seen on the previous scan from [Date] . the medical consultant has apologised for error and discussed with both patient and next of kin . .		[Date] - 72 hour report completed [Date] - decision request sent to DMT for SI [Date] - Decision email from clinical director is this incident is a SI for externally reporting to STEIS reported to STEIS [Date] 72 hour report due [Date] RCA due to patient safety [Date] .	Death
[Healthcare Professional] prescribed 10mg ramipril instead of 2.5mg starting dose .			Severe
On [Date] patient was administered Lantus OD and Novomix 30 BD instead of Lantus and Novorapid . Medical Team recognized the error and corrected this , however patient was given 30 units Lantus at [Time] and another 40 units Lantus at [Time] as a result patient had three (3) severe hypos ranging from [X-Y] mmols . .	[Healthcare Professional] informed , Drug history printed , Duty of candour to be completed by doctor implicated in error . Regular Blood sugar monitor carried out , patient and family aware of the situation . .	RCA attended study session booked and carried out . Education board been produced safety notices on drug trollies , 2 x nurses to check every dose of insulin consultants aware and to provide training on induction . Link nurse been educated been educated on ward in diabetes . Letter sent to patient informing of investigation outcome . .	Severe

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
A [Age] was seen for emergency contraception . She was taking topiramate recently started by [young persons mental health project] for mental health issues and therefore had not been prescribed by the GP practice and wasn't on the system . The patient was prescribed the standard dose of levonelle 1500 . The chemist picked up that the patient was on topiramate when presented with their the prescription the following day and the practice had increased the dose to 3000 as per BNF / CEU guidance . .			Severe
StEIS [Number] The patient was admitted with a back abscess to [Hospital] ED . He was referred to the surgical team for an I+D . He had been on oral flucoxacillin prior to admission and was given IV flucoxacillin in the department . Whilst this was being given he developed tingling to his lips and dropped his blood pressure to 60 systolic and dropped his GCS to [number/15]. He was moved to resus and given IV fluids and IV hydrocrtisone . . He was reviewed by the [Healthcare Professional] and the [Healthcare Professional] as well as several members of their team following this incident . The possibility of this being a an anaphlyxasis reaction is mentioned in several doctor notes . The possibility of it being a syncopal episode is also mentioned . . Later that evening between [Time] and [Time] he has three ECGs in ED that are reported by the ECG machine as showing an acute MI . There is a large amount of artefact on these ECGS but ST elevation appears to be present in V3-4 on these . There is no documentation in the patient notes about the ECGS or any action taken as a result of these ECGs . One of these ECGs has been signed by a doctor . The patient was asked at several times whether he had chest pain which he denied. The patient was subsequently moved to [unit] and at [Time] on the [Date] the [Healthcare Professional] documented that he called the [Healthcare Professional] who advised him that the patient should be given the next dose of IV Flucoxacillin . Within 1 minute of receiving this dose the patient is reported to have become wheezy ,			Death

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
hypotensive and tachycardic . The patient was treated for anaphylactic shock and moved to the critical care unit . . The patient had four ECGS done on [unit] between [Time] and [Time] which show ST segment elevation in leads V2-5 . There is again no documentation in the notes regarding these ECGS and none of these are signed . . Despite ongoing treatment for anaphylaxsis the patient unfortunately went into cardiac arrest at [Time] on ICU and was unable to be resuscitated and unfortunately passed away . .			
[Number] Patient was thrombolysed after being admitted due to being FAST positive . The thrombolysis checklist was completed by Dr [named] who recorded that the patient was not on anticoagulants / antiplatelets , and alteplase was prescribed and given at [Time] . I reviewed the patients medication at approx [Time] , and collated a drug history from the patients ' husband , her dosette medication which was available on a&e and her Summary Care Record . I noted that the patients regular medication included rivaroxaban 15mg OD and aspirin 75mg daily , which the husband confirmed she had taken that morning . I informed the consultant , he was already aware of the situation . I added alerts to her EPMA profile to highlight that she had been thrombolysed so rivaroxaban and aspirin would not be immediately continued . I am unaware of the patients outcome . .			Severe

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
Patient briefly admitted to CDU . Discharged with an [] letter which listed only five medications , based on a drug history which was incomplete . These medications were then instituted on the patient repeat prescription list , and all her other medication was stopped . This was not the intent of the discharging doctor (no medicines were listed as " stopped " on the [] discharge) . .	SEA from Practice : Patient admitted to hospital . Discharged with medication list which transferred to GP repeat prescription systems . Drugs previosuly prescribed were removed from system and patient did not have these after [Date] . Patient readmitted [Date] as hospital had not meant for medication to be stopped . Patient had been without required medication . . Why it happened ? Poor communication of discharge medication . Lack of questioning by practice of reason for altered prescription . . How to prevent ? Full list of mediction on discharge letters . Remove only medication listed as stopped from repeat prescription system . . Changes made - System to alert	What has been learned ? Awareness that [] should state removed items . Be aware of this and question lack of clarity on discharges . .	Severe

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
	repeat prescription system to remove only items specifically listed as stopped . .		
This patient repatriated from another hospital . The patient was high risk for stroke and required treatment dose Tinzaparin . This was not handed over from the night nurses to the doctor doing the admission paperwork . The patient was previously on anticoagulation but was stopped as had haematemesis . The patient was only prescribed prophylactic Tinzaparin by the admitting night doctor . There are no records of these doses being given by the nursing staff over the weekend . Treatment dose Tinzaparin was prescribed this morning on ward round . The patient suffered an acute stroke and began having seizures secondary to this.	Nurse responsible for missed dose spoken to by [Healthcare Professional] and [Healthcare Professional] . Requested to complete reflective practice staement . Further medicines assesment performed . .	Patient transferred from [location] warded at [Time] . Not clerked by medical team till [Time] at which time drug chart was prescribed . Tinzaparin unable to be given due to lateness of prescription . On the [Date] prophalatic dose not given by ward staff . Follwing day on [Date] decision made by consultant for theraputic dose . Dose prescibed for [Time] and given at that time . From the investigation one dose of prophalatic tinzaparin was missed being given . .	Severe

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
I was asked by the [Healthcare Professional] to check a patients [name software system] prescription . Patient was to have 3 weekly carboplatin and weekly paclitaxel for 9 weeks then Epirubicin and Cyclophosphamide for 3 cycles . Patient had her first 9 weeks of treatment but had [a number of] deferrals during the 9 weeks . Therefore she was correctly prescibed an extra week of Carboplatin and paclitaxel and a week of paclitaxel alone . Patient should have had a week off after the single paclitaxel before commencing the EC regime (this is because the carboplatin was a 3 weekly regime) The patient was prescribed EC a week too early . It was screened and given the go a head on [System] by the medical team . Patient recieved treatment . Patient became unwell and eventually presented to [Hospital] A&E . [Healthcare Professional] informed myself she was unwell and on ICU . I do not have any further information . Incident was reported to me [Date] . .		For ERG [Date] . For SI [Date] . Final report in Datix .	Severe

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
[Number] [Age] patient , frail , CCF with severe MR , AF , advanced CKD (baseline creatinine 240) , htn , glaucoma , admitted for mechanical fall with R NOF fracture , cemented hemi on [Date] under general anaesthesia . In recovery low BP , low GCS , pinpointed pupils , reduced respiratory rate to [number] with worsening renal function , metabolic acidosis , T2RF , iperkalemia . Not responded to iv fluid resuscitation , naloxone . Reviewing the drug chart I realised that a high dose of morphine has been given in less than 24 hours considering her creatinine clearance . [...] . On the day before surgery given oramorph 20 mg + 10mg + 10mg+ 10 mg total 50 mg) from the morning to midnight . Oramorph was prescribed by a [Healthcare Professional] and given by different nurses . .	Action plan in place and is being monitored .	[Date] - the coroners report and the toxicology report confirm that [Patient] died of natural causes ; this case will not go to inquest . . SI Investigation [Number] . Findings : " There was no pain score documented on admission and no written recorded pain score documented when administering analgesia . " There were errors with prescribing and administering of opiates and analgesia in relation to [Patient] weight , age and renal function . " No clear documentation in the medical notes regarding the plan of care post - operatively and the pursuance of a palliative course on transfer to the ward . " No communication with [Patient] family regarding the referral to the coroner and the reason for referral . " Poor communication between staff regarding the plan of palliative care for [Patient] . . Recommendations : " Retrospective note review of	Death

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
		the fractured neck of femur pathway to highlight practice gaps with documentation . " Education to all clinical staff about the importance of considering age , weight and renal function when prescribing analgesia . " Robust guidelines for doctors regarding : writing medical certificates , referrals to the coroner office and cremation forms to be implemented and embedded . " Training for [Ward] nursing staff regarding appropriate recording of pain scores . " Review the practice of weighing patients who have had a fractured neck of femur on admission . " Education for all staff about appropriate use of Naloxone . .	

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
Incident discovered as part of mortality review Medical outlier on [Ward] Was on apixaban and haemoglobin dropped from [value to value] . This was not treated and anticoagulation not adjusted and following day patient had fatal cardiac arrest . Not reviewed by any one more senior than [medical rank] level since move to outlying ward Mortality reviewer was of opinion that this was preventable death .			Death
wrong dose of drug given .	This case was discussed at a site case review . This has been escalated as an SI . . This infomration has been completed using the proforma completed during the cyber attack . .		Severe

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
patient became unwell , the patient had copd , she was scoring [value] on mews code red declared , delayed response from code red so escalated to [Number] . [Healthcare Professional] attended unit , assessed patients breathing . Requested 40mg furosemide iv be administered via cannula in right forearm . Oxygen % titrated , assessed again by medical registrar and further 40mg iv furosemide requested to be administered . the patient was to be escalated to A&E an emergency ambulance arranged , but during handover between nurse and paramedic the patient passed away . During completion of documentation , it was noted in the medical notes that the patient had an allergy to furosemide , this was not recorded in the allergy status of the drug card . the patient had had multiple allergies noted has pencillin v , Pregabalin , simvastatin , pravastatin , ceflexin , citalopram , isosorbide mononitrate , felodipine , amlodipine , atenolol , tramadol . the patient had also received oral doses of furosemide which had been prescribed since [Date] , and a stat dose of furosemide orally on [Date] . this was escalated has a possible addition to cause of death . .	Red incident investigation to be completed by [Healthcare Professional] . [Initials] . [Abbreviation] escalated & informed [Number] of concerns & police investigation . Manager on unit attended at approx . [Time] [Abbreviation] being interviewed . System 1 records printed off - record of this admission to the unit . Also identified that it recorded on system 1 in [year date 1 to year date 1 + 2] as a sensitivity to several drugs , clearly recorded that the sensitivity to furosimide was incontinence . [Healthcare Professional] visited the unit & offered her support to [healthcare professional] who was on duty the following day , senior staff to address on [day] after the bank holiday & potential of having to	Please see red incident report , to be attached on completion . [Initials] . To ensure that all sensitivities & allergies are recorded on the drug kardex clearly , that staff ascertain the sensitivities & ensure recorded clearly on system 1 . .	Death

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
	complete a SI . Patients husband also visited the unit to bring in a card of thanks . Police contacted [healthcare professional] that no negligence had been committed . [Date] . Reviewed following police investigation , patient death natural causes . Patient not allergic to medication but sensitivity . No further police instigation . To be investigated as a Trust RED incident after review at the Trust SI panel .		
The patient presented with epigastric pain and was tracked to the surgical team for management of pancreatitis . At this time , it was also noted that the [patient] had hyponatraemia . This was discussed with the [Healthcare Professional] at the time of admission and was advised to start 0.45% NaCl and regular monitoring of Na levels . Once tracked to the Surgical team , we attempted to get in touch with [Healthcare Professionals] to discuss further management of hyponatraemia . The surgical team were unable to get in touch as [Healthcare Professionals] were in clinic . I was advised by the [Healthcare Professional] to try later on after [Time] . I was still unable to contact them . Instead I obtained advice from the [Healthcare Professional] on call that day . The following day , I was able to contact the [Healthcare Professional] who reviewed the patient and prescribed appropriate fluids / Na			Severe

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
replacement (0.9% NaCl) . However that evening , 0.45% NaCl was given prior to the 0.9% NaCl by the nursing staff . They moved chronologically through the prescriptions and the previous 0.45% NaCl was not crossed off prior to prescription of the 0.9% NaCl following the endocrinology review . Na was monitored overnight by the team , it remained stable . The following day , it was noted that on a VBG performed the Na was [number <104] .			
Patient with hyperkalaemia . Protocol for hyperkalaemia not followed . No hyperkalaemia bundle in place , treated as severe hyperkalaemia when was only mild . This was done by the [Healthcare Professional] on call during the night (DR [Letter]) . As a consequence of the treatment with salbutamol 20mg , the patient (with broad past medical history of ischaemic heart disease) became tachycardia and with chest pain and had an MI . .			Severe
The patient was admitted to [Healthcare Provider] on [date] being admitted to [Ward] . Seen by the [Healthcare Professional] on the ward . She noted that he was prescribed Epilim for epilepsy and that he had a history of drinking and was , in her view , withdrawing . The medics dealing with the patient were not prepared to prescribe chlordiazapoxide or pabrinex and apparently did not understand why these drugs should be used in withdrawal . The [Healthcare Professional] at was called and arrived on the ward at [Time] noted that the patient had a long history of fit . He was in obvious withdrawal , he was shaking uncontrolably and glistening with sweat . He appeared to have attaxia and had a nystagmous . [personal	issue communicated with relevant personnel .	need to prescibe appropriate medication for pateints withdrawing from alcohol .	Severe

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
information on large volumes alcohol typically consumed] [Healthcare Professional] on duty was made aware as was the named nurse , both were warned that not giving the required medication would result in a medical emergancy and fit . The [Healthcare Professional] stated that he would call the medical team involved with the patients care . I insisted that the medication was necessary and should be prescribed and administered immediately . The SHO apparently bleeped the responsible medical team and they arrived in the early evening . it is not clear if the patient was administered the required medication . He had fit and was taken to ITU at [Hospital] leaving [Ward] at [Time] . .			
([Initials] email [Date]) : This patient had an ERCP in [Month] for his obstructive jaundice during a two - week visit , prior to his chemotherapy beginning after a second short stay . On both occasions a VTE risk assessment suggested enoxaparin would be started . The INR was never deranged but he received three doses of Vitamin K around the time of his stenting , but no enoxaparin was prescribed , though it was given subsequently on the next stay . After fortnightly chemotherapy treatments , he returned in [Month] and a CTPA showed PE , prior to his death ten days later . .	The failure to prescribe prophylaxis is an example of sub - optimal care . As this occurred [Number] months before the patient developed a pulmonary embolism it is not clear whether this failure to administer prophylaxis contributed to the development of the PE but it is a possibility . The patient had deranged LFTs so this may have led to a reluctance to prescribe prophylaxis on the part of the [Healthcare Professional] but this is not documented or discussed with the	Drs to seek expert help from haematologists / senior colleagues when balancing the risks of the provision of prophylaxis against the benefits to decide on whether prophylaxis should be provided or not . Drs to document their decisions and the rationale for those decisions . .	Severe

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
	responsible consultant . In the view of the responsible consultant the patient should have been prescribed prophylaxis . In view of the fact that this patient has sadly since died [Date] After Discussion with Duty of Candour is not applicable . .		
On [Date] [Initials] , [Healthcare Professional] discussed [Patient] with [Healthcare Professional], regarding medication . [Healthcare Professional] agreed to increase [Patient] Aripiprazole to 10mg but did not have time to visit [patient] with me and had no prescription to write for me to take to [patient]. PLAN : I text [Healthcare Professional] and duty worker , [Initials] , [Patient] [software system] number and plan was made for [Healthcare Professional] to write prescription the following day and an [healthcare professional] clinicial would give it to her at her home address , [Location] on [weekday]. [Healthcare Professional] was made aware by telephone by [Healthcare Professional] of above plan . . I work [Days] . On [Date]I could not access [software system] due to server problems ? to detail above - On return to work [Date] I was informed that [Patient] has jumped from the [Location] on [Date] - psyhc . liaison involved and she is currently an informal admission to [Ward] . . [Healthcare Professional] was on sick leave on [weekday] and I'm unaware of the plan for [Patient] to have a script issued in his absence . .			Severe

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
Patient found to have PE and given 12,500units of fragmin in ED at [Time] . . Patient transferred to ward [Location] given an additional 10,000 units of fragmin at [Time] . . Patient then had large haemoptosis , estimated blood loss 1.5 litres in 4 hours . .	[Date] Handler changed to [Healthcare Professional] for [Healthcare Professional] for concise review . Medical notes requested . [Initials] . Concise review completed and discussed in [place]. Referred for consideration of SI investigation . Duty of candour completed [Initials] reviewed [Date] - please upload concise review and advise actions taken - was pharmacy involved in investigations ? .		Severe
Whilst reviewing a patient charge nurse asked me to investigate potential issues with anticoagulation which may have led to ischaemic leg . Patient transferred from [Location] to [Ward] for ablation and PPM . Normally takes Dabigatran 110mg bd for AF . On [Date] on [Healthcare Professional] had held this as was for a PPM however did not prescribe any enoxaparin . This was not reviewed until [Date] when she had a stat of Enoxparin 40mg prescribed . After this patient developed leg pain and was diagnosed with occlusion and needed thrombolysis and was transferred to [place].		SUI investigation by [Healthcare Professional] . .	Severe

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
The patient was found unresponsive , ? [initials] stroke team for transfer to CT scanner @ [Hospital] as CT scanner not in use at [Hospital] . The patient is usually on warfarin for AF and previous CVI - she was admitted on [Date] overnight @ [Time] - INR [oin range] - clerked but felodipine , metformin and candersartan were not prescribed until [Date] . Warfarin not prescribed until [Date] - INR on [Date] was [low] - normal warfarin dose prescribed , next INR - [low +0.2] on Sun [Date] (no action taken) . On [Date] warfarin not prescribed by day team therefore task sent to on call [Healthcare Professional] to prescribe warfarin and ? needs clexane as INR [low + 0.2]on [Date] - told nursing staff not necessary to give clexane - It was handed over to night staff to give the warfarin but it was not dispensed . The CT scan confirms a thrombus and the patient is currently on ward 2 having treatment . .	Timeline to be completed for an RCA - [healthcare professional] has looked into Trauma Coordinators to be able to access Summary care records . . [Staff Name] - information attached relating to Prescription tasks for Warfarin for this patient as requested by the [Healthcare Professional] .	Medications not checked on admission leading to ommission of antihypertensives , metformin and warfarin being omitted for [number] days - INR then subtherapeutic and no actions taken . .	Severe
[Age] patient presented with massive GI bleed and had to go to theatre . had been seen in ED on [Date] and prescribed naproxen for pain relief . need to investigate why an NSAID was prescribed in a patient of this age . .	[Date] [Abbreviation] - Being IX as a potential SI .		Severe

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
Patient was not given any antibiotics for [number] days . Not prescribed on [System] . .	Incident reported externally as a SIRI . A lead investigator has been appointed and an investigation commenced . . Actions identified in SIRI report : 1 . Development of clear guidance of how to conduct an effective handover [as per Clinical Handover Policy] 2 . Audit of NEWS chart completion and escalation weekly until 100% achieved for a month 3 . Ensure all staff are aware of NEWS escalation protocol 4 . Poster to be shared with all medical staff describing SIRI and learning points including the impact of delays in antibiotic prescription 5 . Arrange teaching session for ward nursing and medical staff about NEWS escalation and sepsis 6 . Complete Duty of Candour with relevant person 7 . [unit] medical	1 . Delay in treatment with antibiotics due to decision made by [Healthcare Professional] to stop antibiotics notwithstanding it was clinically indicated to continue antibiotics and there was delay to senior input in recommending antibiotics . There was then a further delay for [number] hours when antibiotics were then not prescribed and not given . 2 . Failure to follow escalation procedure for the deteriorating patient with failure of nursing staff to escalate and failure of medical staff to review . 3 . Failure in communication at handover , lack of review of medical notes and poor written documentation by medical and nursing team .	Death

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
	team that identified incident to complete training on Duty of Candour 8 . To implement system / SOP on AAU to ensure prescriptions are placed on JAC following ward round 9 . [Healthcare Professional] who made decision to hold antibiotics to undergo supervision and complete reflection 10 . An audit of the implementation of the key actions identified in this report 11 . To discuss Coroners process with Chief Medical Officer 12 . Inform Director [title] of Junior Doctor involvement in a SIRI for routine reporting to the Deanery . [unit] staff to complete BLS training .		

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
A [gender] patient admitted with back pain and advanced pulmonary disease was prescribed opioid analgesics by [Healthcare Professional] on the ward . The [Healthcare Professional] on the ward prescribed 20 mg of Oramorph at [Time] . Then about [number] later , the [Healthcare Professional] instructed nurses to give 15 mg of subcutaneous morphine . The patient had severe pulmonary disease as comorbidities . She became drowsy later on that day . In the evening , the drowsiness induced by morphine resulted in aspiration to her lungs . Night on - call team was called by nurses on the ward as she had raised NEWS score and was drowsy . The clinical evaluation of the patient revealed aspiration pneumonia . The patient deteriorated significantly . She did not respond adequately to the full medical treatment and continued to deteriorate further . .	Patient was admitted with severe back pains which was being investigated . She had high dose of opoid which resulted in respiratory depression and subsequently aspiration pneumonia . Nursing staff on evening shift has not documented any care given and patient deteriorating condition was not escalated . Statement requested from all staff on duty . Will be discussed on the next staff meeting , Discussed daily during hand over about the need to adhere to Trust policy regarding monitoring of unwell patient and record keeping policy . Family updated of incident . [Healthcare Professional] in conducting further investigation . Recommendations Prescribing doctor had meeting with [Healthcare	Patient pre - existing medical condition Staff education of monitoring unwell patient . Root cause A patient admitted with a suspected infective exacerbation of long standing lung disease and who had a low oxygen level on admission , received an additional stat dose of Morphine sub cutaneously [number] minutes after an initial oral dose to control back pain , on a background of a mix of PRN and regular opioids already issued in the preceding 24 hours . This additional morphine prescription was a specifically directed one by the [Healthcare Professional] and checked by the doctor with the issuing nurse , who did not challenge it . Non - adherence to prescribing guidelines on Opioids as per recommendations within the BNF meaning too high a dose and subsequently cumulative dose was used . Non - adherence or Trust Medicines Management regarding the prescribing of PRN (as	Severe

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
	Professional] and to receive further education re use of opioids / supervised with prescriptions and for was documented as part of their revalidation . Junior doctors named in Serious Incidents are reported to the Trust Lead to report to the Deanery for tracking of performance issues across the region as junior doctors move placements . No formal disciplinary action was taken in this incident . . Ongoing education regarding escalation to Level 1 pathway and escalation . Posters now displayed in the Ward areas by Practice Development Team . Short cut to the pathway to be put on Google Drive App for fast reference on doctors mobile devices . This report will be shared with the Rapid Response	required) drugs with variable routes despite the drug having variable potency. This prescription therefore increased the risk of this particular patient becoming susceptible to aspiration pneumonia due to drowsiness from excess doses of opioid medication . The patient's condition was such that she had insufficient physiological reserve to survive a further respiratory illness , however her initial presentation could also have contributed to her naturally deteriorated with chest infection . .	

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
	team also for their team learning . . Ward leads to embed culture of escalation at board rounds , requesting handover of NEWs scores and concerns and ensuring markers on the bed board to highlight these patients and their observation and review requirements . Ensuring high NEWs are highlighted at the morning Safety Huddles where Rapid Response are present to pick up concerns . . There is a prescribing test at the end of the Medicines Management session and the plan currently is to provide feedback of trends to the new doctors . This will also help pharmacy focus on where there are weaknesses and tailor training as appropriate in future . The lessons need to be shared . . To share the lessons with		

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
	the division in the Morbidity and Mortality meeting and via the Divisional Shared Learning Newssheet . .		

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
Given 420mg gentamicin 120mg at [Time] [Date] 300mg at [Time] [Date] - note says needs 5mg / kg At the time Actual weight 88kg Ideal body weight 60kg creatinine 398 Cockcroft - Gault creatinine clearance = 12ml / min So according to Trust Guidelines (1) maximum dose should be 3mg / kg (CrCl 20) (2) she fits the nomogram for obese so the ideal body weight should be used Therefore the dose should have been 180mg . This is likely to have resulted in profound loss of vestibular function such that the patient currently finds it difficult to leave the house . .			Severe
Patient discharged from hospital and we received a set of new prescriptions , with new drugs and changes to existing medication , which we dispense in MDS tray , delivered weekly on a [weekday]. These changes were implemented at the beginning of [Month] . . Today [Date] received a call from the practice pharmacist at the patient surgery asking why we were supply Hydroxycarbamide as this was being supplied by the hospital pharmacy and therefore patient was receiving a double dose . [Staff Name] , the nomad dispenser , checked and advised that we had prescriptions and a copy of discharge notes , neither of which indicated that we were NOT to supply . .			Severe
[Healthcare Professional] in [Specialty] at [Hospital] noted patient ([Age] year old [gender], moderate frailty , hypt bp &lt ; 140 / 80 , CKD chadvasc = 3) not on anticoagulation for his AF whilst reviewing his [rare disease] . They advised GP start on Apixaban after discussion with patient about risk vs benefits . GP started apixaban at correct dose 5mg BD but next day admitted to ED at [Hospital] with bilateral epistaxis . No mention of being on DOAC in ED notes and patient discharged with no follow up . Then [time] later had a haemorrhagic CVA . ? missed opportunity . Where is the evidence for using DOAC in [Age Range] year olds and should we not mandate hospitals to collect data on drug related admissions to help us all make better decisions about anticoagulation . GPs feel			Severe

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
under pressure to prescribe DOACs by hospitals advising them when GPs know patients best and maybe they are the ones who should have the risks v benefits discussions , which are not easy at best of times . this is a recurring problem and as a [Healthcare Professional] in practice I am intending to start reporting them all via this system .			
PATIENT PARENT CALLED TO TELL ME HE HAD DEVLOPED A CORNEAL ABRASION AND HAD LOST A LARGE PART OF HIS VISION . SHE STATES IT WAS DUE TO A LACK OF HIM HAVING EYE DROPS PRESCRIBED WHILST ON [Ward] THOUGH HE HAD GONE HOME AND HAD BEEN FOR SEVERAL WEEKS WHEN THE ISSUE WAS HUGHLIGHTED TO US HE HAD BEEN SEEN IN CLINIC AND ALSO CONVERSATIONS ON THE PHONE WITH PARENTS BUT ONLY THE DATE ABOVE WAS THIS ISSUE HIGHLIGHTED PATIENT HAS LONGSTANDING FACIAL PALSY 15 PLUS YEARS AND IS ON REGULAR EYE DROPS TO PREVENT DRY EYE AND CORNEAL DAMAGE PARENT STATES TOLD WARD STAFF SEVERAL TIMES THAT THE DROPS NEEDED PRESCRIBING MUM STATES THAT HE HAS SEEN LOCAL OPHTHALMOLOGY WHO DESCRIBE NEW LOSS OF ESSENTIALLY ALL VISION ON RIGHT EYE THAT IS DIRECTLY DOWN TO THE LACK OF EYE DROPS AS NOT PRESECRIBED PATIENT WAS ALSO ON NEURO HDU AND ICU DURING STAY .	.[Date] Concise SI .		Severe

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
The current known facts taken from notes . cardiac arrest on ward with unclear aetiology leading to admission to intensive care . Digoxin level taken as seen to be on high dose whilst on clarithromycin finds a toxic level [number] subsequent evaluation of [software system] suggests since [Date] has been receiving in total the equivalent of [number] loading doses of digoxin which has ultimately led to this toxic digoxin level . in addition patient was on antibiotics known to affect digoxin levels and despite this no digoxin levels done on system despite further loading doses of digoxin given on multiple occasions given this is an iatrogenic toxicity which potentially may or may not have caused this patients cardiac arrest it needs looking into .			Severe
Patient was re - started on Dianette in a telephone appointment . She was not weighed / BP monitored and no documentation of any risk factors / advice re VTE etc . smoking status was not documented . Her work involved lots of long haul travel and shortly after starting dianette she was diagnosed with a DVT . .			Death

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
In retrospect - During the admission for elective surgery a patient on steroids for vasculitis , were omitted which cumulated in severe kidney damage . .	Incident reported externally as a SIRI . A lead investigator has been appointed and an investigation commenced . Clarify roles in pre - assessment process , including responsibilities for abnormal results and findings Consider provision of appropriate clinic time for anaesthetic review of complex patients prior to day of surgery , especially if already turned down for an anaesthetic . Review of orthopaedic ward medicine management at [Hospital] and [Hospital] in conjunction with the pharmacy department Ward meetings to review and discuss the incident , ensuring that if something is not going to plan , the patient is involved in that conversation Renewed	1) Comprehensive and accurate clinical assessment is required 2) Timely and appropriate treatment needed 3) Effective communication is essential .	Severe

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
	focus and training on the orthopaedic wards on completing datix across all disciplines Discuss and review AKIs at the Orthopaedic governance meeting , review how the patient is managed , and how the junior team escalate Collect the information from the above actions , and ensure there is a multi - disciplinary discussion about mechanisms to discuss patients appropriately before surgery . Take report back to [group] on changes of process Complete Duty of Candour with relevant person An audit of the implementation of the key actions identified in this report .		

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
We became aware of potential concerns about possible chemical contamination following the sudden and unexplained death of a [Age] patient who was being supplied with PN by [System] via [healthcare provider]. Potential impact for 24 patients receiving PN from same supplier immediately reviewed to understand balance of risks of stopping / continuing PN . Decision to contact and recall all 24 outpatients to clinic the following day to undertake , blood gases , observations and other blood tests . All necessary agencies informed (Police already aware as SUDI) , MHRA , NHSE , CCG informed . All internal stakeholder informed and aware of clinical pathway should any patient on PN attend or contact us unwell. A second line of investigation that would fit the clinical picture was also identified as it appears that the deceased patient did not receive their usual soluble vitamins in the PN due to error (s) that occurred somewhere between prescription and administration . All PN prescriptions , transcriptions and order forms for the other patients were checked , no additional error were found Internal Incident run by [healtcare professional]. Log available . .		There is separate RCA set up for this IR1 - therefore will be closed following the outcome . [Name] That the Pharmacy Management Team review the work processes and resources of the PN - Pharmacy team so that they are required and able to seek the correct approval of changes to PN prescriptions and formulations 2 The PN Pharmacy team to review our prescriptions against the formulations we receive to determine if it possible to design a format we could introduce to mitigate risks which are apparent. 3 We increase resilience in the pharmacy PN team through increasing the number with skills in checking 4 The [Healthcare Professionals] are trained in understanding the formulation so that they can act as a true double - checker .	Death

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
Patient admitted [Date] to [Abbreviation] following a fall . Fracture of R Radius . Patient prescribed paracetamol and oramorph on admission by site team . Patient had a creatinine of [number] and egfr of [number] ml / min on admission . Fracture fixed on [Date] . No bloods taken for U+E on [Dates] . Patient hypotensive in recovery . Nephrotoxic drugs and anti - hypertensives given on [Date] and[Date] including lisinopril , indapamide and atenolol . Gabapentin (taking on admission) and codeine (newly prescribed) given post operatively . Oramorph given post operatively . Patient encouraged to increase oral intake [Date] by ward team . Unclear if patient able to eat / drink as needed following surgery ? Major trauma practitioner notes that patient struggling with nausea , patient slurring and difficulty with word finding . Physio on [Date] limited by low blood pressure . Patient reviewed [Time] on [Date] as NEWS=[number] . Plan : day team to review . NEWS=[number lower] at next observation . [Date] [Time] - ward round , patient drowsy , unable to move left arm , GCS [number] , myoclonic jerks . CT scan - nil acute . Morning bloods on [Date] reveal AKI level [high]. Renal review , referred to ICU . ICU admission with pre - renal AKI , gabapentin toxicity , opiate toxicity at [Time] .	training provided for all RN on [Location] in AKI and Opioid toxicity , RCA reported to staff in news letter . .	[Date] - division management team have declared this incident an SI for externally reporting to STEIS Corporate [group] 12 midday today [Date] [Healthcare Professional] and team RCA (SI [Number] [software system] [Number]) completed .	Severe
drug chart re written [Date] , VTE completed but Dalteparin not re prescribed . patient was on 2,500 units prior to drug chart being re written . nursing staff asked Drs to prescribe Dalteparin but was not not completed . Patient had a cardiac arrest and CTPA showed Pulmonary embolism . transferred to critical care unit . consultant for neurology had been informed that the deltaparin had been omitted because of the subdural haemorrhage multiple pockets in the cervical / upper thoracic spine .	drug chart had been re written and VTE assessment had been copied from previous chart and not re assessed . Deltaparin not prescribed , Stockings prescribed . Statements obtained from the staff involved and sent to [Staff Name] for investigation from	DRs to reassess VTE not transcribe from previous chart . Nurses to ensure DRs are not preforming other tasks and interrupting drug prescribing to reduce errors made .	Severe

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
	[Abbreviation] [Staff Name 2] . RCA completed . .		
Px admitted with DKA . As per protocol put on fixed rate insulin , which states 0.1units / kg / hour up to a maximum of 15 units - to be increased by 1 unit an hour if targets not met . . Estimated body weight was 70kg , therefore px started on 7 units / hour insulin - as per protocol . This was increased to 10 in hour 3 of treatment , before being increased again to 15 units / hour in 4 . . This resulted in glucose falling from 47 on admission to 6 in 6 hours . Target drop is a drop of 3mmol / hour glucose . . Admitted to ITU ventilated after dropping GCS and becoming agitated post DKA correction . CT head was unremarkable on [Date] . Px has failed sedation holds and remains low GCS . Working diagnosis is that this is caused by cerebral oedema secondary to rapid correction of glucose . This diagnosis has not been confirmed . .			Severe
Patient with a past history of hyponatraemia was commenced on indapamide as treatment for hypertension , alongside ramipril .			Severe
Patient admitted on [Date] , prescribed prophylactic dalteparin 5000 units OD administered at [Time] . Patient then prescribed treatment dose dalteparin for ?PE , 18,000 units dalteparin prescribed (incorrect dose , dose as per weight should have been 15,000 units) which was administered at [Time] . Patient therefore received 23,000 units of dalteparin on [Date] . 18,000 units OD administered on [Date] . .	SI declared [Date] . For SIG presentation [Date] . Ref [Number] Presented to SIG [Date] and submitted to CCG [Date] . Report attached . .		Death

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
Hospital sent written advice on increasing a specific medication for a patient .			Severe
Prescription for domperidone and lansoprazole dispensed at [Time] in the morning and patient collected later in the day . Received a phone call from the prescribing doctor checking we had dispensed this medication and had been collected . He informed me that the patient had a coronary and had died . The GP (Dr [Staff Name]) said he wasn't sure if any of the medication had been taken by the patient . The [] system gives a warning and contraindication with Ranolazine 375mg dispensed on [Date] but this had not been seen during dispensing . .			Death
Patient came in via A+E for emergency L CFA endarterectomy , L iliac stent and L medical thrombectomy . . Started on heparin (5000units bolus , 1.4ml / h starting rate) at [Time] Baseline [Time] APTT ratio [value]. APTT ratio [Time] [value] . Went to theatre at [Time] , plan to cont . Notes state patient oozing as on clopidogrel . (it says somewhere else that this was stopped [number] days ago) , so unsure which is right . . Heparin 2,500 units bolus given at [Name] . End of surgery : plan to cont iv heparin with the aim of 2.5 APTT ratio . APTT ratio [Time] [value], [Time] [value]. Protamine 100mg given [Time] , APTT ratio [value] at [Time] 1unit blood (no heparin) given after 2 operation . Required metaramminol for hypotension and 2 units bloods on ICU . Documentation not very clear when prescribed on drug chart - is there a separate iv heparin rx that I have not seen ? .	[Initials] [Date] - reviewed incident and realocated to surgery failure to respond to Increased APT happened within theatre . please involve me in RIR when arranged . .		Severe

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
Patient seen in [section of] A&E at [Hospital] during busy time where lots of ambulances arriving at same time . Patient handed over by ambulance crew to myself (name removed) . Patient conveyed to Hospital for lower limb bilateral cellulitis and ulcerated R lower limb . In ambulance crew handover , no known drug allergies (NKDA) . Patient had recieved Co - Amoxiclav in the community previously . Patient seen in [unit] by myself and a brief history taken including allergies history . Patient forthcoming on multiple occasions to have no drug allergies . When notes for the patient arrived in [unit] benzyl penicillin and flucloxacillin prescribed (as per trust protocol) by myself . Medications given after patient stating that no drug allergies present . I was then called to attend patient after benzlpenicillin infusion finished and flucloxacillin infusion just starting when patient became unresponsive . Initially patient making no respiratory effort . Patient then had an iGel inserted and bag - valve mask ventilation commence .	Patient denied penicillin allergy .	Act with caution if allergy documented even if patient denies allergy . .	Severe
Patient admitted for elective knee replacement . Regime for post op dalteparin not followed . 5000 units was advised by anti coagulation however 15000 was prescribed . .	upload [Abbreviation] Investigation underway Timeline completed . Awaiting panel review [Abbreviation] [Date].		Death
Patient had been admitted on the [date] with a pleural effusion and chest infection oral anticoagulation (apixaban) was stopped to perform pleural aspiration . . Apixaban was not restarted on discharge Summary stated held until definitive diagnosis As a consequence of the lack of oral anticoagulation the patient had an acute ischaemic stroke on the [Date] Mortality review E .			Death
PATIENT PRESCRIBED ANTICOAGULANT BY SECONDARY CARE IN [Month. Year] UNDER SHARED CARE . PRACTICE TOOK OVER PRESCRIBING AFTER 3 MONTHS . PATIENT PRESENTED SEVERAL TIMES TO SURGERY BUT ONLY 1 MONTHS SUPPLY WAS PRESCRIBED . PATIENT ATTENDED			Death

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
FOR HIS REPEAT MEDICATION WHICH WERE GIVEN HIS ANTICOAGULANT WAS NOT PRESCRIBED AS THIS HAD NOT BEEN PUT ON REPEAT . PATIENT DIED OF A PE ON [Date] .			
[software system] [patient] number [Number] . Blood pressure medication stopped by [Healthcare Professional] yet was still issued by EPS . Pt discharged from [Hospital] on [Date] due to collapse / low BP . Bendroflumethiazide and bisoprolol and lercanidipine stopped by hospital and clearly indicated on discharge letter dated [Date] . [Healthcare Professional] reviewed pt at home and checked BP as appropriate on [Date] . On returning to surgery [Healthcare Professional] amended medication and removed all 3 drugs . In addition any pending requests were cancelled . Later pharmacy requested these 3 drugs via EPS and they were issued even though they had been cancelled by the [Healthcare Professional] earlier the same day . This error was only discovered later by the family who submitted an informal complaint . It appears that EPS allowed this error as the pharmacy request took place minutes before the pt medication list was amended by the [Healthcare Professional] . This was unknown to the [Healthcare Professional] at the time and was placed in the routine EPS for routine electronic prescribing.			Severe
[software system] [patient] number [Number]. Blood pressure medication stopped by [Healthcare Professional] yet was still issued by EPS . Pt discharged from [Hospital] on [Date] due to collapse / low BP . Bendroflumethiazide and bisoprolol and lercanidipine stopped by hospital and clearly indicated on discharge letter dated [Date] . [Healthcare Professional] reviewed pt at home and checked BP as appropriate on [Date] . On returning to surgery [Healthcare Professional] amended medication and removed all 3 drugs . In addition any pending requests were cancelled . Later pharmacy requested these 3 drugs via EPS and they were issued even though	[NOTE APPARENT DUPLICATE REPORT		Severe

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
they had been cancelled by the [Healthcare Professional] earlier the same day . This error was only discovered later by the family who submitted an informal complaint . It appears that EPS allowed this error as the pharmacy request took place minutes before the pt medication list was amended by the [Healthcare Professional] . This was unknown to the [Healthcare Professional] at the time and was placed in the routine EPS for routine electronic prescribing.			
On reviewing a repeat request which included some meds for 7 days and 2 controlled drugs MST 10mg and 30mg) the Dr noticed that the patient was requesting the CD a month before it was due . The patient had previously overordered CDs before . The Dr suspects that this happened because as some of the meds were blistet packed but the CDs were on the list and issued a month at a time . The Dr declined to prescribe the CDS and invited the patient to the surgery to discuss . The patient declined to see the Dr but choose to go to another Dr in this practice in two weeks time.			Severe
Pharmacy was obtaining medication history for a patient on [Ward] on [Date] . This patient had been admitted on [Date] to [Ward] . The following problems were found : 1 . This patient had brought her own medication into hospital in a blister pack which listed her usual medication (found in bedside drawer) . No regular medication had been prescribed on medication chart since admission . Usually medication included Levothyroxine , medication for blood pressure and angina and inhalers . Discussed with doctors on [Ward] today to review to avoid more missed doses . 2 . Patient was prescribed Oramorph on admission despite a documented allergy to Morphine on medication chart . The documentation did not state what reaction the patient had to Morphine . She received two doses since admission . Discussed with doctor on [Ward] to review today . 3 . Patient was on insulin prior to admission . After discussion with the			Severe

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
patient (using written questions as she could not hear) and diabetic team (hospital) it was found that her usual dose of Humulin M3 was fourteen units in the morning and twelve units in the evening . On admission [Date] she had been prescribed and given forty units in the morning . Patient had hypoglycameia on [Date] and [Date] . .			
when conducting my medication reconciliation for a patient admitted [Date] I noted from my drug history that the patient was taking novomix 30 insulin bd , but this had not been written up on the drug chart . .			Severe
post NOF NSTEMI 300mg clopidogrel loading dose was never prescribed , despite cleared from bleeding risk point of view by ortho [Date]. (Basics of MI medical / conservative management) . Not sure what happened with the possibility of thrombolysis / angio / angioplasty ? [healthcare professional] contacted by ICU docs . Second MI [Date] . Also noted patient not on aspirin for secondary prophylaxis by [Healthcare Professional] despite previous MI , but note alcohol history . I did not investigate this with [Healthcare Professional] . .	[Date] [healthcare professional] Allocated to [healthcare professional] for review and added [healthcare professional] as investigator . [review] arranged for previous incident reported [date] .		Death
Patient due to be transferred to the [Hospital] for dialysis but his condition deteriorated and pulse dropped to 35bpm . Seen by CCOT and [Healthcare Professional] and referred to Cardiology . Seen by cardiology team who realised that pt had been prescribed Bisoprolol 2.5mg daily and it should have been every other day due to his renal function . The pharmacist had realised that it was wrong and had noted it on the drug reconciliation part but had not written in green on the actual prescription . .	overview meeting [Date] Presented at Serious Incident Group Meeting [Date] . .		Severe

IN07 Description of what happened	IN10 Actions Preventing Reoccurrence	IN11 Apparent Causes	Reported Degree of harm
Admitted on [Date] for haematuria , edoxaban for AF held . Haematuria resolved and was urologically fit for discharge the next day , VTE risk re - assessment not done . Edoxaban not restarted , plan was ' edoxaban to restart on discharge ' - reason for this unclear from clinical notes . . Patient stayed in the hospital because of social issues . On the [Date] , he went into cardiac arrest and died . Reason for death according to post mortem report is bilateral PE . .	Urology outlier - reassigned . Patient had LD - safeguarding informed . Possible LeDeR review also required . Draft timeline completed - issues highlighted and sent to urology team . DoC needed - unclear who the patient consultant is . [Date] STEIS checklist complete . [healthcare profesisonal] . [Date] - report completed - for [group, Date] and [group, Date] . Family written to [Date] - see attached (also on EPR) . .		Death
The patient was an [Age] [gender] who had a recent hip replacement and was admitted on the [Date] following fever with rigors . She was treated for sepsis from an unknown source . She had a past history of essential thrombocythaemia and was on hydroxyurea . This medication could not be prescribed by the admitting team and as per pharmacy , was referred to haematology for prescribing . She only had the medication prescribed on the [Date] . She however had aspirin and enoxaparin prophylaxis . She unfortunately suffered an acute coronary syndrome on the [Date] and passed away . The fact that the medication was missed needs highlighting in order to prevent future problems . .	[healthcare professional] reporter & Medical Division preparing a report with input from the Medicines Safety Officer . Request made to Medicine Division re the [form] being reported for [Ward] which means it sits within the [Unit] . .		Death

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Our [Patient] is currently prescribed 200mg x 2 at night of lithium . When [Issuer] last issued medication the packet was 200mg strength label said 400mg take 2 at night . Their last request from [Issuer] was for 400mg take 2 at night . Our doctor ignored the incorrect request and issued the correct dose . It is very fortunate that this was caught and corrected as this would have had a very bad effect on our patient . .			Severe
[Age] patient with extensive cardiac medical history was treated for Staph Aureus positive Blood Culture with Gentamycin 240mg / d for six days . Gentamycin levels increased up to [number] and the patient developed subsequent renal failure , needing Intensive Care and renal replacement therapy . .	Datex reviewed by [Initials]and discussed with Dr[Staff Name 1] . Gentamicin started [Date] for ?staph A endocarditis as per micro at dose of 5mg / kg as per BNF . Post - dose checked [Date] (sunday) by ward nursing team but unfortunately not acted upon . Monday was bank holiday so normal doctor team weren't around to review . Reviewed by normal day team on tuesday [Date] who straight away discussed with micro (Dr [Staff Name 2]) and he advised to decrease the dose of gentamicin to 200mg which we did . Gent level checked the following day - came	Best not to prescribe gentamicin at 6am when there are no doctors around to act upon the result . Starting gentamicin over a busy bank holiday weekend is risky - although there seems to be no way to avoid this if the drug is needed . .	Severe

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	back as number] and we consequently stopped the gentamicin completely . Throughout this period patient was also receiving rifampacin , when kidney function started to deteriorate we consulted the BNF which said to decrease the dose of rifampacin , so we halved the dose . We were unaware this drug was likely contributing to the patient renal failure until the [Healthcare Professional] kindly came to review the patient and instructed us to stop the drug completely , which we immediately did . .		
This was initially received as a complaint ref :[Number] . Patient was under [Specialties] as outpatient and had admissions via ED . Patient was being investigated for CA and Vasculitis . The patient received high dose oral Prednisolone , High dose IV Methypredisolone , Aspirin 75mg and then Aspirin 300mg and Ibuprofen 400mg tds . The patient was seen by many doctors and pharmacists but no gastric protection was prescribed until after the patient had undergone surgery for a perforated ulcer . The patient was admitted to ITU where he deteriorated and died . .	[Date] - 72 Hour Report rec'd - PC PSF [Date] - New Serious Incident STEIS [Number] Investigating Officer : To be confirmed Executive Lead : Medical Director 72 Hour report required : Completed For review at [] Review Group meeting		Death

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	: [Date] Deadline for papers for SE Review Group Agenda :[Date] Contractual deadline for CCG : [Date] .		
I was called at [Time] by [Unit] to place an "urgent cannula" for a patient for IV fluid and IV antibiotics for a "very septic" patient . My consultant and I were very busy that morning . My consultant got a chase up call at [Time] and shortly after I was able to attend . I placed an ultrasound guided cannula (also took some blood from it and gave it to the team looking after him - there is a blood gas timed [Number]) . In doing so I also alerted them to the fact he had a functioning cannula . I went back to the ward at [Time] (to retrieve my tourniquet) at which point the patient informed me that "the cannula has not been used" so I spoke with nurse in the bay and she said no IV Abx or fluid were prescribed . I then found a doctor (who said the patient was not hers) to alert them , she said she would find and chase it up . I later found out that not until [Time] was it flagged up again to the anaesthetic department that he did not have a functioning cannula which means a cannula was in for 5 hours in a " septic patient " with no ivabx given and no other route of Abx was given until late on the [Date] which is roughly 12 hours of the diagnosis of sepsis without any antibiotics (longer than that if taken from his admission) .	[[Date] [Time] [Staff Name]] Added further medication details for data completeness . Risk grading inputted to enable saving . Handler to review risk grading . Changed to harm (from near miss) as patient did not receive medication in a timely fashion . .		Death
Patient was admitted to [Hospital] acutely with a fractured Rt . Neck of Femur on the [Date] . He was known diabetic with chronic kidney disease but his Ace - inhibitor was not stopped . On the [Date] he underwent hemiarthroplasty during which he was given Gentamicin 120 mg IV . He then developed a stage 1 AKI on the [Date] , progressing to Stage 2 on the [Date] and stage 3 on the [Date] . He continued to be prescribed his ACE - inhibitor which reduces renal			Severe

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perfusion and increases the risk of AKI until after his blood results on the [Date] were back . He required renal intervention and dialysis including vascular catheter insertion (risk of bacteremia) and acute hemodialysis (risk of cardiac strain) on the [Date] . .			
patient was prescribed tramadol - Marol 200mg MR1 twcie a day on a repeat prescription and was given 2 months supply (112 tablets) on each prescription . The prescription was a continuation from her previous practice where she was prescribed Marol tqablets 200mg MR . One tablet twice a day . Dosage of Marol [Tramadol] never changed during the time treated at the practice. post mortem showed that the patient died of tramadol toxicity . Death caused practice to review quantities of Marol prescribed . In 2016 the dates of 112 Marol was prescribed as follows :[Multiple dates] . the patient has been able to obtain Tramadol more frequently than the repeat prescription had been set up for and the practice investigated as a significant event to look at their repeat prescribing systems . .			Death
Please copy to Dr. [Staff Name] - [Email] Please note drug name on form listed as Fluconazole as Itraconazole not in list of choices . . Patient with reasonable kidney function on a statin regularly following a stroke . Attended Respiratory OP Clinic and was prescribed a trial of Itraconazole . . Patient presented to A+E with dyspnoea , dysuria and dark urine . Impression UTI . U+Es normal on admission . . Patient anuric , found to have severe AKI and hyperkalaemic refractory to treatment . Admitted to ITU for haemofiltration . Found to have high Creatinine Kinase . . Cons . Renal opinion was AKI was multifactorial and drug error possibly contributed towards it . Unfortunately despite maximal management patient deteriorated and died . .	for the incident to be investigated as above to determine the level of harm .	for the incident to be investigated - 72 hour scoping meeting to be arranged with representative from [place].	Severe

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Patient A&E with UTI . Given 400mg IV gent . Balance has been very poor ever since . [gender] sustained vestibular toxicity. I don't know how much [personal description of small size and weight]. I think [gender] has been given an excessive dose of gentamicin poisoning [gender] inner ear balance mechanism .			Severe
This [Age] was discharged on [Date] following a Left Middle Cerebral Artery (MCA) ischaemic stroke . Unfortunately , he had not been prescribed Clopidogrel on discharge . This was not noticed by the prescribing doctor , nor by the Pharmacist dispensing the medication nor the nurse handing over the prescription to take away (TTAs) to the patient . He therefore did not have any antiplatelets on discharge (Aspirin 300 mg was stopped on discharge as is routine for the stroke patients) . He then re - attended with a further stroke on the [Date] . While we can not say with certainty that he would not have had a stroke had he had Clopidogrel on discharge , the likelihood would have been somewhat reduced . It is highly likely though that the Electronic prescribing and medicines administration (EPMA) prescribing system - all members of staff are still getting familiar with - did not aid in preventing this oversight . .	This [Age] [gender] was discharged on [Date] following a L MCA ischaemic stroke . Unfortunately , he had not been prescribed Clopidogrel on discharge . This was not noticed by the prescribing doctor , nor by the Pharmacist dispensing the medication nor the nurse handing over the TTAs to the patient . He therefore did not have any antiplatelets on discharge (Aspirin 300 mg was stopped on discharge as is routine for the stroke patients) He then re - attended with a further stroke on the [Date] . While we can't say with certainty that he would not have had a stroke had he had Clopidogrel on discharge	Importance of checking all documentations that relates to inpatient medications both in the patient clinical notes and reconciling this with the electronic prescribing system . .	Severe

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	, the likelihood would have been somewhat reduced . The discharge medications previously was cross checked with paper drug chart previously prior to the introduction of the electronic prescribing system . This is to ensure that all inpatient drugs are prescribed on discharge . The new electronic system means that this additional check no longer happens and medications are transcribed on the system directly with limited additional checks . . There was also missed opportunity for the full list of the medications on discharge TTA to be checked by the nursing staff looking after the patient and the ward pharmacist . .		

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Patient prescribed and administered a loading dose of aspirin 300mg and ticagrelor 180mg due to a diagnosis of possible ACS . However patient was already on warfarin for AF and at the time the antiplatelets were administered his INR was [high]. The patient was also prescribed clarithromycin and ticagrelor should not be administered concurrently with clarithromycin as it may markedly increase the effect of ticagrelor . This could lead to an increased risk of bleeding so 1mg vitamin K was administered on [Date] afternoon with aim of reducing INR to range 2-3 as PE was a potential diagnosis . .	[Date] 72hr review to be undertaken [Abbreviation] Pharmacy notified upon submission . [Date] all nurses involved contacted and will write statements , safety alert performed to ALL critical care staff and will be discussed at safety huddles [Date] Pharmacy update incident discussed at SI panel and decision made for RCA .		Severe
Patient had been admitted following a fall and sustained a fractured Neck of Femur . Was unwell DNAR advised and also had ?bowel obstruction . Not for theatre to fix #NOF , Following General surgical review was for a CT scan but required sedation prior to scan . Midazolam 5mg administered IV . Scan completed and patient returned to ward . Acutely unwell , peri arrest / respiratory arrest . Patient deceased [Time] . .			Death
This [Age] [gender] was admitted on [Date] under the surgical take with abdominal pain . He was diagnosed with [surgical emergency managed via rare conservative procedure] He has a history of coronary stenting and until admission was taking regular aspirin to reduce the risk of stent thrombosis . His aspirin was not prescribed during this admission despite the pharmacist highlighting this omission . The patient was discharged without aspirin and admitted again with worsening abdominal pain on [Date] . The following morning he developed chest pain and his ECG showed ST segment elevation . .			Severe