length of hypoglycaemic episodes and shorten treatment duration for babies.

REFERENCE

Aim To perform a retrospective analysis of tenfold medication errors between the 1st January 2017 and the 31st December 2018 and identify contributing factors.

Method Information from all tenfold medication errors reported to the Ulysses system between 1st January 2017 and 31st December 2018 which met the criteria was inputted into a data collection sheet. Information gathered included the age of the patient, the time the error occurred, the location within the hospital, the point in the medication process the error occurred, the drug involved and the NCC-MERP category of harm assigned to the error. Reports were excluded if they were repeated entries or if they did not meet the criteria for a tenfold medication error. The total number of medication errors reported per month and the total number of admissions per month was also identified. Once data collection was complete, these errors were qualitatively analysed and compared with those of a previous audit using errors reported from 1st January 2013 to 31st December 2014.

Results Tenfold errors were most likely to be reported in the Critical Care areas (34.4% of tenfold errors being reported over the two-year period). Prescribing was the most common origin of error accounting for 54.3% of tenfold errors in 2017 and 51.7% in 2018. The most common category of harm assigned was category B (no harm – error did not reach patient) with a total of 40.6% of the errors reported. The age group with the highest number of errors reported was 29–364 days with 39.3% tenfold medication errors reported over the two-year period. Morphine was the most common drug involved accounting for 13.8% of errors reported.

Conclusion The findings from this report mirror the results from the previous audit performed in 2014 in respect to error origin and patient age. Tenfold prescribing errors have more chance of being intercepted before reaching the patient due to there being more steps in the process before administration, therefore it is less likely that errors that originate at prescribing will reach the patient. Tenfold administration errors were more likely to reach the patient and therefore to cause harm. Morphine was the most reported drug in both 2017/18 and the 2013/14 audit suggesting that more work needs to be done on the safe use of opioids. Critical Care was the location with the highest number of errors reported, patients in this area often require complex medication regimes increasing the likelihood of being involved in a medication error.

REFERENCE