Shared learning

Theme of the week

Incorrect medication prescription that led to medication error

Date

24/02/2025

Background and context

Situation: On 28/10/2024, patient was started for discontinuation of Clinically Assisted Nutrition and Hydration. The order for SC medications on Day 9 was increased to 30mg morphine, 90mg midazolam, and 1.4 mg glycopyrronium to run for 24 hours via syringe driver.

What happened?

Error in preparation of subcutaneous medication via syringe driver related to Incorrect prescription. Patient received 8 mls bolus by mistake. Syringe driver was drawn up to 30mls instead of total volume of 22 mls.The incident was escalated right away to the WM after starting the SD at bedside.Immediate actions were taken. The staff reported that out of the 29-30ml syringe of the prescribed medications, approximately 5 mls of this was lost through priming when trying to fit the syringe in the driver which led to it not being administered and he received a bolus of approximately 2-3mls maximum and not 8mls in total as initially thought.

What should have happened?

-Prescription for SC meds should have been reviewed by the GP and CRS/WM to ensure that the right dose is calculated rightly for the syringe driver prior to prescribing it on EPR
-GP to liase with Palliative Care Team if with queries regarding increasing the dose of SC medications via syringe driver
- Ideally, SC medications should only be in total of 22 mls per 30 mls BD syringe. Considering a second line of syringe driver should be done if the total volume is more than 22 mls

What we will do differently next time

-RN to escalate to GP/ CRS/WM if the ordered dose of SC meds has been increased and is more than 22 mls volume per syringe
-GP to check prescription prior to putting it on EPR and discuss queries with CRS and Palliative Care Nurse lead
-Syringe driver training should be delivered to all nursing staff
-Preparation of Syringe Driver must be done in the clinical room as a protected environment
-Syringe driver equipment quantities must be reviewed

What have we learned?

-Correct prescription of SC medications must have been done prior to RN carrying out the new medication order
-If SC medications' volume goes beyond 22 mls, then a second line for syringe driver must be set up
-CRS must be called and be present during preparation of syringe driver medications for clinical supervision if appropriate training was not delivered to the nursing team yet
-Syringe driver training should be delivered to all nursing staff
-There should be an available syringe driver device to be used for the next syringe driver cycle to avoid interruption with the ongoing SD

☑ I have read this

Name	Job role	Signature