BOARD OF DIRECTORS MEETING (Open)

Date: 11 July 2018 **Item Ref:** 09

TITLE OF PAPER	**Controlled Drugs Accountable Officer (CDAO) report to the Board of Directors**
TO BE PRESENTED BY	J Peter Pratt CD Accountable officer
ACTION REQUIRED	1) To review the report 2) Raise question and challenge if necessary
OUTCOME	BoD is assured that 1) The governance arrangements for the management of controlled drugs and relevant people are fit for purpose 2) CDAO acts in line with statutory requirements to prevent the harm from controlled drugs by relevant people.
TIMETABLE FOR DECISION	July Board
LINKS TO OTHER KEY REPORTS / DECISIONS	Patient safety Medicines optimisation risks and processes CQC assurance processes
STRATEGIC AIM STRATEGIC OBJECTIVE BAF RISK NUMBER & DESCRIPTION	To ensure the safe use of controlled drugs by relevant people. To ensure shared intelligence to prevent harm from controlled drugs
IMPLICATIONS FOR SERVICE DELIVERY AND FINANCIAL IMPACT	Delivered within allocated resources
CONSIDERATION OF LEGAL ISSUES	–The Human Medicines Regulations 2012 http://www.legislation.gov.uk/uksi/2012/1916/pdfs/uksi_20121916_en.pdf –The Health Act 2006 and subsequent updates. –The Controlled Drugs (Supervision of Management and Use) Regulations 2006 The Controlled Drugs (Supervision of Management and Use) Regulations 2013 http://www.legislation.gov.uk/uksi/2013/373/pdfs/uksi_20130373_en.pdf

Author of Report	J P Pratt
Designation	CD Accountable officer & Chief Pharmacist associate
Date of Report	30th May 2018

SUMMARY REPORT

Report to: **BOARD OF DIRECTORS MEETING**

Date: 11 July 2018

Subject: Controlled Drugs Accountable Officer (CDAO) report to the Board of Directors

Presented by: JP Pratt CD accountable officer
Dr Mike Hunter Executive medical director

Author: J P Pratt

1. Purpose

For Approval	*For a collective decision*	*To report progress*	*To seek input from*	*For information*	*Other (please state below)*
X					*assurance*

2. Summary

This reports provides an overview of the reported incidents relating to controlled drugs and relevant people.

There is reasonable evidence to support the conclusion that

1) Safeguarding and information sharing relating to serious concerns across the local arm of the CD LIN is continuing to work well.

2) A serious incident led to a review and strengthening of the systems and processes relating to control of FP10 prescriptions and the management of returned medicines.

3) The CD incident reporting rate rates continues to rise.

4) There are reasonable grounds for assurance that the CDAO was aware of and, where appropriate, acted on incidents in relation to major concerns about controlled drugs and relevant people.

3. Next Steps

1) Incident review and sharing across the LIN will continue

4. Actions

1) The Medicines safety officer will review the actions and risk assessments in relation the management of CD patches through the medicines safety committee
2) The medicines safety officer will implement a revised monitoring system for small discrepancies
3) The medicines safety officer will work with the Executive medical director and other colleagues to support an improvement in the timeliness of investigation of non major incidents of concern

5. Monitoring Arrangements

Sheffield Arm of the regional CDLIN
Medicines optimisation committee to oversee the actions of the MSO and medicines safety committee
Quarterly LIN reports to be reviewed by QAC
CDAO meets Executive medical director on a monthly basis

6. Contact Details

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Controlled Drugs Accountable Officer (CDAO) report to the Board of Directors

May 2018

J P Pratt, CD Accountable officer

Purpose of the report

To ensure that "safe management of controlled drugs" in maintained as an organisational priority.

To provide assurance on the systems and processes within SHSC that lead to the safe management of controlled drugs.

To describe the range of incidents reported to the CDAO from October 2016 – March 2017.

To update the BoD on the major concerns raised in last years (2016) report.

To advise the BoD of the changing time frame for the CDAO report

To highlight the recommendations from the CQC 20156annual report on controlled drugs (published August 2017).

Background

In January 2000 Doctor Harold Shipman was convicted of the murder of 15 of his patients using the drugs diamorphine (heroin) and morphine. Reports also suggest that he may have used these drugs to kill many more of his patients, possibly around 250.

Following Shipman's conviction, the secretary of state for health asked Dame Janet Smith to lead an independent enquiry into the case and make recommendations to protect the public from harm by relevant people using controlled drugs.

Between 2002 and 2005 six reports were published under the chairmanship of Dame Janet Smith. These led to the legislative changes which were introduced in the 2007 Health Act to strengthen the governance arrangements surrounding the use of controlled drugs by "relevant people".

As part of the statutory requirements contained within the 2007 Health Act organisations such as NHS trusts were required to appoint a controlled drugs accountable officer (CDAO), who was responsible for the assurance of safe use of controlled drugs throughout the organisation. Other requirements included the sharing of information (or intelligence) across organisational boundaries and a duty to collaborate. Where there are strong grounds for concern a CDAO must share intelligence with other bodies such as the police, the NHS counter fraud service, the care quality commission (CQC) or registering bodies such as the General Medical Council, the Nursing and Midwifery Council, and the General Pharmaceutical Council.

In 2013 new legislation was introduced (The Controlled Drugs [Supervision of Management and Use] Regulations 2013) which brought the previous medicines and CD legislation in line with the NHS organisational changes. This legislation was put in place to ensure that the overriding aim of the CDAO continued to be to protect the public from harm in relation to controlled drug use by relevant people. The NHS England South Yorkshire and Bassetlaw area team CDAO is responsible for co-ordination the sharing of information through Local Intelligence Networks (LIN's). To support her in this task the Sheffield CCG head of pharmacy co-ordinates the functions of the Sheffield LIN.

Information concerning all incidents relating to controlled drugs is reported by the SHSC CDAO to the Sheffield LIN and the SHSC quality assurance department on a quarterly basis.

Controlled Drugs

In August 2012 the legislation covering medicines for human use was revised and consolidated into a new act – The HUMAN MEDICINES REGULATIONS 2012. This legislation updated the 1968 medicines act and incorporated various changes introduced by EU legislation together with all the updates and variations to the original act.

There is a degree of complexity surrounding the laws relating to medicines and CD's, but in general terms the main legislative points to note are:

The Misuse of Drugs Act 1971 (MDA 1971)
This act primarily covers the illegal use of drugs and provides a schedule system for classification of these drugs. This system of classification provides the courts with guidance on the maximum sentences to be imposed if this law is broken (Schedules A, B & C).

The Misuse of Drugs Regulations 2001 (MDR 2001) (and subsequent amendments)
Covers the medical use of those drugs listed within the MDA 1971. Within the context of MDR 2001 the classification system for the medical use these drugs defines the drugs by a different system of schedules (1, 2, 3, 4 & 5). Within this context these drugs are classified according to their likelihood of harm vs therapeutic benefit. With Schedule 1 drugs being the most tightly controlled in terms of prescribing, dispensing, storage & transportation and Schedule 5 having the least control. Schedule 4 also includes anabolic steroids.

The British National Formulary (BNF) gives details of the legal status of most of the medicines used in the UK. Although the full list of controlled drugs is currently under review, the Chief Pharmacist/CDAO would be expected to intervene in all cases where there may be a concern about the use of these drugs by relevant people. Further details can be found on the home office website http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/drug-licences/controlled-drugs-list – including contact details for advice on whether or not a specific substance is a controlled drug. (DLCUCommsOfficer@homeoffice.gsi.gov.uk)

Management of Controlled Drugs (CD's)

Following the murderous activities of Harold Shipman in the 1990's it became clear that the systems and process of control that were in place at the time to govern the use of CD's were inadequate. Following the fourth report of the Shipman enquiry in 2004, the chairman Dame Janet Smith concluded that the governance arrangements for these drugs needed to be strengthened.

Many of her recommendations from the enquiry were incorporated into part three of the 2007 Health Act and statutory instrument No. 3148 The Controlled Drugs (Supervision of Management and Use) Regulations.

http://www.legislation.gov.uk/ukpga/2006/28/pdfs/ukpga_20060028_en.pdf

http://www.legislation.gov.uk/uksi/2006/3148/pdfs/uksi_20063148_en.pdf

One of the key changes introduced by the 2007 Health Act was the statutory requirement for NHS trusts (and other relevant bodies) to appoint an accountable officer for controlled drugs (CDAO).

In December 2015 further changes to legislation took place which enforced the use of new controlled stationary by anyone ordering stocks of controlled drugs. It appears that an unintended consequence of this legislation may result in a significant additional bureaucratic requirements for anyone receiving – or supplying controlled drugs outside of the legal entity of a NHS Trust. No exemption can be applied to

NHS trusts such as SHSC where small quantities of controlled drugs are supplied to other NHS trusts and all NHS trusts are required to submit standard requisitions in order to transfer stocks of controlled drugs between themselves.

Statutory role of the controlled drugs accountable officer (CDAO)

The requirement for designated bodies to appoint a CDAO was made in the 2007 Health act and has been reiterated in subsequent legislation. The CDAO must ensure that his designated body has adequate arrangements for the safe and legal management and use of controlled drugs throughout the organisation.

The overriding concern of the CDAO is to protect the patients and public from harm due to controlled drugs by relevant people. There are a number of specific duties of the CDAO. Full details of the duties of the CDAO are laid down in Part 2 of The Controlled Drugs (Supervision of Management and Use) Regulations 2013 (http://www.legislation.gov.uk/uksi/2013/373/part/2/made).

The CQC are required to hold a record of all CD accountable officer (and ensure all relevant organisations are registered with them. See http://www.cqc.org.uk/content/controlled-drugs-accountable-officers)

Duties of the CDAO include ensuring that:

- The organisation is following “adequate and up-to-date” standard operating procedures (SOP’s).
- Appropriate arrangements for monitoring and auditing the management and use of controlled drugs.
- Systems exist to alert the accountable officer of any complaints or concerns involving the management or use of controlled drugs.
- The incident reporting system captures untoward incidents involving the management or use of controlled drugs.
- Appropriate arrangements in place for analysing and responding to untoward incidents involving the management or use of controlled drugs.
- Relevant individuals receive appropriate training in relation to controlled drugs.
- Arrangements are appropriate for monitoring and auditing the management and use of controlled drugs by relevant individuals and assessing their performance.
- The recording of any concerns raised in relation to the management or use of controlled drugs by a relevant individual.
- The assessment and investigating of any concerns raised regarding the management or use of controlled drugs by a relevant individual. The CDAO must determine whether these concerns should be shared with a responsible body.
- Appropriate action is taken to protect patients or members of the public in cases where concerns in relation to the management or use of controlled drugs by a relevant person appear to be well-founded.
- Appropriate arrangements for ensuring the proper sharing of information.

The designated body (board of directors) has a responsibility to ensure that they notify the CQC of the name of the CDAO and that s/he is a “fit, proper and suitably experienced person” who does not ‘routinely supply, administer or dispose of controlled drugs as part of his or her duties’.

Notification to the CQC should be done through the relevant section of the CQC website (http://www.cqc.org.uk/content/controlled-drugs-accountable-officer-notifications) - Note this notification section is password protected and the CQC must be contacted in advance for a password to enable on line notification.

The BoD can be assured that the CQC hold details (as at May 2018) of the CDAO for SHSC as follows:

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As part of their responsibilities the designated body must remove their CDAO from office if they no longer satisfy the conditions for appointment or if s/he is unfit to be an accountable officer.

If the CDAO neglects their duties either wilfully or through lack of competence the designated body must remove him/her from office and appoint an alternative CDAO. Designated bodies are also required to ensure that the CDAO is provided with the necessary funds and resources to carry out his responsibilities.

CD Recommendations of the Care Quality Commission (CQC)

The CQC scrutinise and report on how well NHS trusts and other agencies work together to ensure the sharing of intelligence/information on the safe management and use of controlled drugs by relevant people.

As part of this work the CQC publish their findings annually, together with recommendations on how the safe use and management of CDs can be improved. (See Appendix I)

In July 2017 the CQC published their latest (2016) annual report see

http://www.cqc.org.uk/sites/default/files/20170718_controlleddrugs2016_report.pdf

Of the 3 recommendations made by the CQC in their 2016 report The BoD are advised of the following that relate to SHSC and the CDAO

1. Controlled drugs accountable officers should ensure that all staff in their organisation know how to report concerns about diversion and abuse of medicines by fellow colleagues, and that these issues are handled sensitively and appropriately.

2. Prescribers must make sure that they review patients regularly, depending on their clinical need. This is to ensure that the prescribed controlled drugs and length of treatment continues to be the most appropriate for their condition and to reduce opportunities for over prescribing and diversion.

SHSC Assurance statement

The BoD should note the adjustment of the reporting period. This extended reporting period allows for future reports to be scheduled from April – March.

The CDAO makes the following statements of assurance to the BoD in relation to controlled drugs and relevant people.

BoD should note the following.

1) Serious concerns relating to controlled drugs are investigated and actions taken to prevent recurrence.
2) The CDAO shares serious concerns relating to controlled drugs and relevant people with NHS England Yorkshire and Humber LIN and CDAO
3) The CDAO attends the Sheffield arm of the regional CD LIN
4) Changes to the administrative systems which support the production of the quarterly CD LIN reports have resulted in delays in submission of the report. This was exacerbated by formatting and structural changes to the reporting system requested by the LIN.
5) The support for the CDAO will be strengthened by the appointment of a new senior pharmacist medication safety officer (MSO) and substantive Chief pharmacist in July 2018.

Update on Issues reported to the BoD in the previous annual CDAO report (2015-2016)

1) Substance misuse in house electronic prescribing system – relates to initial concern raised in 2013 and again in 2014

Update 2018. All indications are that the arrangements to strengthen and support improvements to the electronic prescribing system with the substance misuse service has been successful. There were no incidents reported which indicate outstanding weakness in this prescribing system.

2) Delays in reporting/awareness concern (all incidents). There were, at times, delays between the occurrence of an incident and the CDAO being informed.

Update 2014 There has been a considerable improvement in this over the past year, and it is expected to improve further with the continued role out and refinement of the electronic incident reporting system throughout the trust.

Update 2015 Improvements in the timely reporting of CD incidents continue. The trust MSO continues to work with the risk department to improve the quality of reporting and learning from CD incidents.

Update 2016 The timeliness of reporting of incidents has improved – but the overall increase in the number of incidents has led to delays in fully investigating incidents. The interim Chief Pharmacist (in agreement with the CDAO) has agreed to update the SOP relating to the investigation of small discrepancies of schedule 3,4 & 5 controlled drugs in an attempt to create the capacity for timely investigation of incidents.

Update 2018 the improvements in the timeliness of reporting and investigation of incident not considered serious, have not been maintained. Systems for tracking low level discrepancies have not been introduced. It is expected the support systems will be strengthened by the appointment of the new Trust chief pharmacists and medication safety officer in July 2018.

Trends in Incidents reported to the CDAO (October 2012- September 2018)

(Note" year" relates to period ending September i.e reporting period Oct – Sept)

	2017	2016	2015	2014	2013	2012
Total CD incidents reported to CDAO	266	242	220	143	96	115
Incidents relating to schedule 2 CD's	49	20	29	18	23	22
Incidents relating to schedule 3 CD's	26	62	24	7	8	10
Incidents relating to schedule 4 CD's	173	146	154	97	55	60
Incident relating to schedule 5 CD's	5	2	3	2	3	1
Unscheduled or not listed because of other reasons e.g. multiple drugs/schedules	13	12	10	19	7	22

See Appendix II for summary of all incidents

Trends in incident reported to CDAO March 16 – April 2018

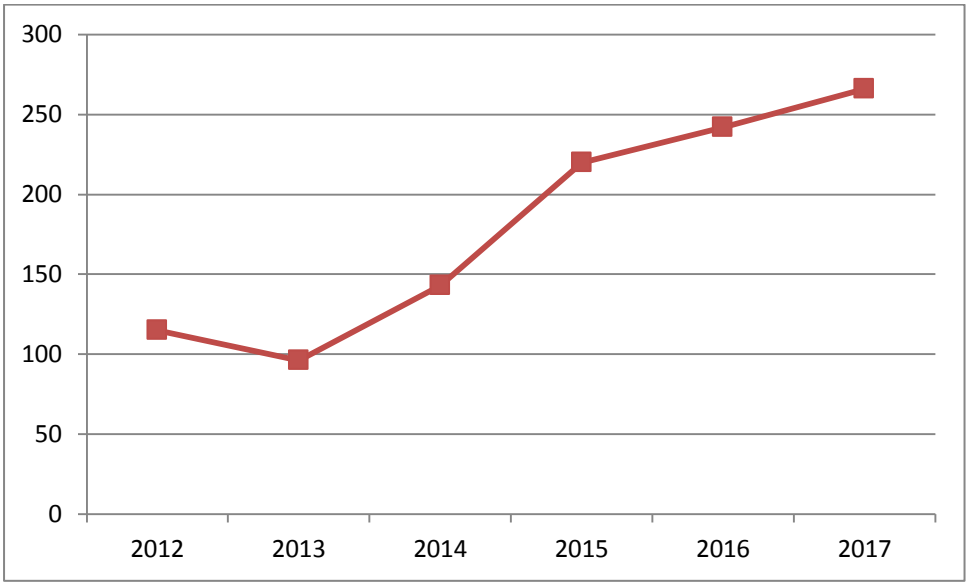
	2018
Total CD incidents reported to CDAO	253
Incidents relating to schedule 2 CD's	30
Incidents relating to schedule 3 CD's	27
Incidents relating to schedule 4 CD's	181
Incident relating to schedule 5 CD's	0
Unscheduled or not listed because of other reasons e.g. multiple drugs/schedules	15

A total of 266 incidents were reported to the CDAO throughout the period Oct 2016 – Sept 2017. This will be the last time data is reported Oct – Sept. In future the reporting periods will run from be April- March.

A total of 253 reports were received in the period April 2017 – March 2018

All these incidents either have been – or will be shared with the Sheffield arm of the NHS England South Yorkshire & Bassetlaw LIN and also with the SHSC Quality Assurance Group. (Depending on the reporting period requested by the LIN.

The annual trend in reported incidents involving all controlled drugs in shown below (Oct 12- Sept-17)



Review and investigation of incidents

Almost all incidents were reported to the CDAO through the trust electronic incident reporting and management system – “safeguard”. Occasionally the CDAO is informed directly through other routes such as the CDLIN or personal contact/intelligence. As soon as the CDAO is informed about an incident involving controlled drugs and relevant people, he makes a judgement about the potential seriousness of the issue and the need to protect people from harm.

In cases of known or suspected serious or major concern the CDAO will act immediately and inform the Chief Executive and Medical Director and where possible will put systems in place to prevent further harm. If the CDAO believes that there are strong grounds for major concern he will share information with other relevant bodies e.g. Local intelligence network (LIN), professional bodies, Police, Care Quality Commission (CQC), etc.

All reported CD incidents should be subject to a brief initial assessment by the medicines safety officer (MSO) as a triaging process for the CDAO. A prioritised investigation is triggered if the CDAO or others suspect that the incident may be a major concern.

In cases where the management investigation of a reported incident is considered insufficient, the MSO will try and interview the staff involved, their manager and any other relevant people in order to triangulate and verify information received. Details of individuals’ behaviour in relation to relevant SOP’s, their medicines related training and their involvement with other CD or medicines related incidents are all considered and recorded as part of the MSO investigation process.

The investigation/review continues until the CDAO is satisfied that there is a complete picture of what went wrong, why it went wrong and what action is necessary to prevent further occurrence. The incident is then classed as “closed” by the CDAO

There are cases where there was insufficient information, or it was impractical to gather more details. Rather than leaving these as open – “or on-going”, but where these is little prospect of gather more detailed information e.g. staff leaving then these incident will be classed as “ technically closed”, but re-opened if further information comes to light through other incidents. Details of all incidents and subsequent investigation are held by the CDAO in both hard copy format as well as electronically within a spread sheet. The trust safeguarding system should also contain details of the incident, but as yet it has not been possible for this system to capture any associated information (e.g. copies of paper records).

An additional complexity to the recording system is the introduction of a new/standard CD incident reporting system by the LIN. It was originally expected that all submissions to the LIN should be through this on line reporting tool, but due to incompatibilities with the trust safeguarding system and the subsequent need for duplicate entries we have suspended use of the CD LIN reporting tool and reverted back to our original reporting format. The new MSO will review and stream line our reporting systems to ensure timeliness of reporting and where possible adoption of the new CD LIN reporting system.

The previous reporting system enabled interrogation by the CDAO’s using a Microsoft Excel spread sheet. This enabled patterns or themes to be identified which may highlight a major concern about a relevant individual and the risk of harm to people over a period of time.

Issues of serious or major concern (October 2016 – March 2018)

One serious Incident 132664 of major concern

Fraudulent prescribing by nurse.

A nurse obtained trust FP10 prescriptions and used these to self-prescribe controlled drugs. Further investigation revealed that this person may also have taken returned patients medicines into their own possession. In addition to the CDAO investigation including the shared intelligence with the Regional CDAO, the trust counter fraud officer and the police liaison officer the trust has also conducted a SUI into the circumstances of this incident. The trust investigation is considered complete, but the CDAO's and police CD Liaison officer are continuing to collect evidence in relation to this incident and in order to understand the scale of the issue.

Following this incident the interim chief pharmacist was asked to review and updated the policies and procedures relating to the storage and control of FP10HP prescriptions and the systems of control over the management of returned medicines. The medicines policies have been updated in the light of this incident.

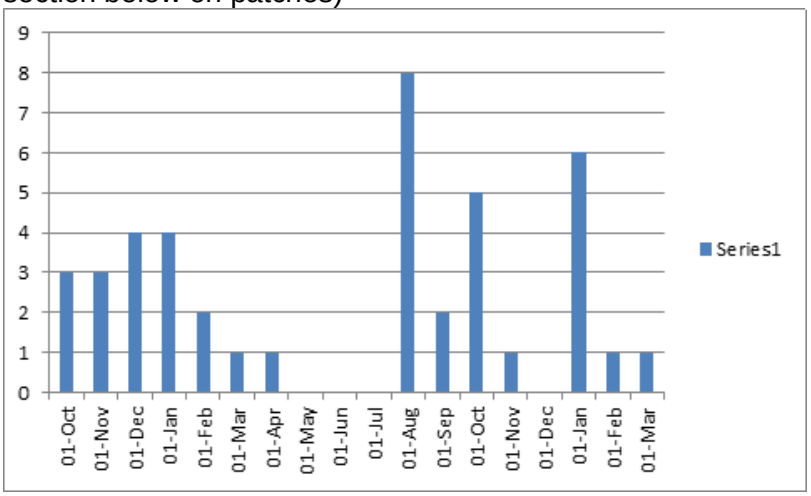
Two possible serious incidents were reported to the CDAO – but subsequent investigation revealed no concerns.

1) Concern relating to the possible use of prescribed medicines for criminal assault. This was raised as a possible serious incident with the CDAO. A full investigation was undertaken by the CDAO and information shared with the Regional CDAO. This reflated that medication was prescribed appropriately by the trust staff and that SHSC was highly unlikely to have dispensed medicines that were used for criminal activities by a patient. Outcome – no concern

2) Concern relating to the possible poor prescribing practice of a doctor several years ago whilst involved with a private clinic. A full investigation was undertaken by the CDAO and information shared with the Regional CDAO. This revealed no concerns.

Continued concerns relating to controlled drug patches.

Previous CDAO reports have highlighted concern relating to the number of incidents involving controlled drug patches. Reports continue to be received, despite a substantial amount of training and support from both pharmacy and the lead consultant Nurse. Whilst there continue to be reports relating to patches, it is felt that these reflect individualised aspects of care in relation to specific patients. (See Schedule 3 section below on patches)



Incidents relating to CD patches (Oc16 – Mar18)

Management and infrastructure support to the CDAO

In previous reports the CDAO highlighted the issue of support for the management of investigation and infrastructure of incidents in previous reports to the BoD. The trust – through the medical director has supported the systems to update and strengthen the Trust pharmacy service and the support the CDAO. A new permanent Chief pharmacist has been appointed and will take up post July 2018. In addition a new medicines safety officer (MSO) has been appointed and will take up position in August 2018, with an interim MSO covering the vacant position until August.

Other issues (October 2016 – March 2018)

Not all reported incidents concerned relevant people who were employees of the Trust. Some incidents involving schedule 2 drugs were "interface" issues with community pharmacies of others not employed by the trust. Details of these incidents were shared with the Regional CDAO and/or the relevant organisation's CDAO and the local arm of the LIN.

Schedule 2 CD's

The trend showing a rise in the number of reported scheduled 2 incidents/occurrences has re-emerged. In the year Oct – Sept 17 the number of incident relating to schedule 2 CDs almost doubled, after falling the previous year.

Outcomes to prevent reoccurrence included additional training and awareness sessions for staff on controlled drugs. Information was shared with Local arm of Regional CD Lin in relation to interface issues.

It should also be noted that the previous CDAO reported that " …. One possible explanation [for the reduction in schedule 2 CD incidents] may be the appointment of a dedicated pharmacist to work with the substance misuse team, but as yet, this has to remain a speculative factor as there is insufficient data to confirm a direct correlation. "Unfortunately funding was not available to maintain support for this post through SHSC. The clinical director of substance services suggested that the interim chief pharmacist could explore funding opportunities that may exist outside the trust. The new chief pharmacist will be asked to reconsider this approach to supporting substance misuse services and schedule 2 controlled drugs.

Schedule 3 controlled drugs

The majority of incidents relating to schedule 3 controlled drugs relate to controlled delivery "patches".

A possible trend in increased incident relating to CD patches was highlighted in the previous CDAO report.. Although incidents involving patches continue to be reported the interim MSO advice is that many of these incidents are reported as being related to individual patients rather that a representing a more widespread problem..

In order to ensure the safe use of patches in the unit where most patches are prescribed the following action plan has been put in place in order to reduce the risks associated with CD patches.

1) The GP will be asked to review of pain medications to ascertain if another form of medication would be appropriate.

2) If the patient is to remain on a patch then increased monitoring is put in place – a body map is used to record where the patch has been placed and patch checks are added to the eMAR system for that patient to ensure that they take place. The number of patch checks per day is based on a risk assessment and can range from daily to multiple times a day.

The interim medication safety officer (MSO) has asked the unit to increase their recording around risk assessments and actions taken in relation to patches for each specific patient so that this can be audited.

Previous actions have included change of brand which appears to have improved adhesion . Staff have also been advised to consider when the patches are being applied i.e. the skin should be clean and dry when possible so immediately following showers/baths would be avoided wherever possible.

In addition to the improved management of CD patches, the drop in the number of reported schedule 3 incidents may be due to a fall in the number of incidents involving tramadol due to the increased awareness of tramadol as a schedule 3 CD. (Tramadol was made a schedule 3 CD in 2016)

Schedule 4 controlled drugs

As noted in previous years, many incidents relate to incidents involving schedule 4 drugs. Of these, "stock balance discrepancies" account for 56% of reported incident Oct16 - Sept 2017 and 63% (Oct16 - March 18) The vast majority relating to a small number of tablets or liquid.

Finding the root cause for these minor discrepancies often remains elusive. The CDAO had previously reached agreement with the executive team that the focus of investigating these small scale stock discrepancies should switch from an attempt to scrutinise in detail every report – but instead look for anomalies arising from plotting patters of supply and discrepancies.

The new chief pharmacists supported by their MSO will be asked to review and update the systems for logging and reviewing small scale stock discrepancies so that unusual patterns of trends can be spotted and where appropriate a more detailed review of practice undertaken.

Although the incidents reported do not representing a serious risk to safety per se – it is, never the less , an issue of concern to see continued reports of" wrong dose" incidents relating to schedule 4 medicines. This was also highlighted in the previous CDAO report.

The interim MSO has been asked to review the pattern of response to these incidents through her medicines safety committee with a view to strengthening the arrangements for staff awareness and training on dose related errors.

The Sheffield arm of the South Yorkshire & Bassetlaw LIN

This body continues to function and is well attended by CDAO's. Meetings are held 6 monthly and reports requested quarterly

Clover group

Scrutiny and monitoring of the staff within Clover Group's use of CD's continues to be undertaken by NHS England South Yorkshire & Bassetlaw clinical support unit. This is done as part of their overall arrangements for the monitoring of CD's in general practice and primary care.

There are reported causes for concern about the management of controlled drugs by relevant people within clover group and the monitoring arrangements through NHS England will continue in line with the rest of the GP practices within the CCG.

Outstanding themes that remain under review.

1) Timeliness of investigation relating to “non major” CD incidents.
2) Medicines safety committee review and recommendations to address “incorrect administration of medicines”

Conclusion

The overall the pattern of incidents involving CD’s and relevant people within the Trust indicate that:

1) Safeguarding and information sharing relating to serious concerns across the local arm of the CD LIN is continuing to work well.

2) A serious incident led to a review and strengthening of the systems and processes relating to control of FP10 prescriptions and the management of returned medicines.

3) The CD incident reporting rate rates continues to rise.

4) There are reasonable grounds for assurance that the CDAO was aware of and, where appropriate, acted on incidents in relation to major concerns about controlled drugs and relevant people.

5) The largest number of reports relate to schedule 4 controlled drugs (as in previous years)..The MSO will work with the new Chief pharmacist to implement a new system to monitor patterns and trends in relation to schedule 4 incidents to ensure the timeliness and appropriate level of investigation.

6) The medicines safety group will ensure oversight of the actions to support the safe use and administration of opioid patches

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GPC number 2023122
CD Accountable Officer, Sheffield Health & Social Care NHS FT May 2018

Appendix I

SHSC Occurrence Report – Controlled Drugs Concerns Reported Between Oct 2016 – March 2018

Description of concern	Schedule	Date aware	Actions taken
09/03/2016 (Incident number 118264) Service notified of the death of a client. Coroner's inquest outcome: Cause of Death: 1a) drug (opiate) toxicity Conclusion: Drug related No further action requested by Coroner	2	13/10/2016	No actions requested by the Coroner post inquest **Closed from Accountable Officer's perspective** **CLOSED**
29/08/2016 (Incident number 123636) Nurse recorded the remaining amount of morphine sulphate as 47.5mls instead of 37.5mls.	4		• Weekly stock checks have been implemented and documented in the CD register • Reviewed with nurses in supervision – no competency / arithmetic concerns identified
03/09/2016 (Incident number 122153) Verbal order procedure not followed . On-call doctor was contacted and verbally agreed 3.75mg zopiclone could be administered to a client which was then given immediately. On-call doctor then contacted the ward to report that zopiclone shouldn't be given as the client was allergic to it.	4	04/10/2016	• Updated junior Dr training and incident shared with Directorate
21/09/2016 (Incident number 122257) Admitting doctor recorded a note on JAC stating that a client could have 10mg diazepam at night however this was not prescribed on JAC. A nurse subsequently followed the note and not the prescription and administered 10mg diazepam, not the prescribed 5mg dose.	4	06/10/2016	• The note has since been suppressed to avoid future errors • Staff member reminded to check the dose on the prescription • **Closed from Accountable Officer's perspective** **CLOSED**

21/09/2016 (Incident number 122431) 3x5mg diazepam tablets missing during benzodiazepine check.	4	03/10/2016	• Ward to continue with CD stock checks • Pharmacy technician to flag up discrepancies if found on ward top-up **Closed from Accountable Officer's perspective** **CLOSED**
05/10/2016 (Incident number 122511) Afternoon dose of medication was given twice in error. Medication included oxazepam.	4	05/10/2016	• Roll out of e-mar system – will this prevent incidents **Closed from Accountable Officer's perspective** **CLOSED**
09/10/2016 (Incident number 122636) Weekly benzodiazepine audit indicated that there was a discrepancy of 1x7.5mg zopiclone table missing.	4	10/10/2016	• All qualified staff reminded that two nurses need to check medication when it is dispensed. **Closed from Accountable Officer's perspective** **CLOSED**
09/10/2016 (Incident number 122653) Medication not prescribed correctly on admission which resulted in a client missing 3 doses of 200mg morphine sulphate. Was prescribed as 200mg every three days instead of 200mg 3 times a day.	2	10/10/2016	• Ward pharmacist aware of incident and checking medicines reconciliation has been done for new admissions over weekends • On-call doctor reminded to check prescription carefully after items have been prescribed as per JAC training **Closed from Accountable Officer's perspective** **CLOSED**
11/10/2016 (Incident number 122691) When completing benzodiazepine count, found 3x 500mcg clonazepam missing.	4	12/10/2016	• Ongoing investigation • Pharmacy to continue monitoring small discrepancies. • Management have reminded staff to record dispensing as per SOP. **Closed from Accountable Officer's perspective** **CLOSED**
12/10/2016 (Incident number 122747)		13/10/2016	• Client put on 10 minute observations following return from NGH Client was originally admitted due to

Client found unresponsive and unrousable in his bedroom. He'd been quite agitated earlier and earlier refused to attend NGH for his USS doppler for suspected DVT. According to JAC he hadn't received any prescribed medication since 14:20 that afternoon.			overdose - risks are being managed in the community by restricting medication supply to 7 days **Closed from Accountable Officer's perspective** **CLOSED**
10/10/2016 (Incident number 122879) Community chemist had refused to dispense medication as prescribed as they said that the dosage was too high. Clonazepam 500 mcg tablet. 1mg (2 tablets) twice daily.	4	19/10/2016	Consultant was informed then contacted the chemist and issued another prescription minus the PRN **Closed from Accountable Officer's perspective** **CLOSED**
20/10/2016 (Incident number 122910) Resident's matrifen patch was found on the floor by his wife.	3	20/10/2016	• Patient specific plan in place due to number of incidents • Incident review was not done - Manager to share with the team regarding importance of incident reviews **Closed from Accountable Officer's perspective** **CLOSED**
21/10/2016 (Incident number 122952) Whilst dispensing a client's MST medication, staff nurse accidentally gave 400mg instead of the prescribed 200mg dose.	2	24/10/2016	• Medicines management training planned for all staff MST 200mg have been removed from the CD cupboard to prevent any further errors
22/10/2016 (Incident number 122953) 7.5mg zopiclone was administered to a client in error instead of 3.75mg.	4	24/10/2016	• Greater diligence needed when administering medication. **Closed from Accountable Officer's perspective** **CLOSED**
23/10/2016 (Incident number 122981) Staff noticed that a client's pain relief patch was missing when they were administering a new one.	3	24/10/2016	• Patient specific plan in place due to number of incidents Incident review was not done - Manager to share with the team regarding importance of incident reviews **Closed from Accountable Officer's perspective** **CLOSED**
23/10/2016 (Incident number 122993)	3	24/10/2016	• Incident discussed in supervision with staff member • Medicines with respect assessment set

Patient is prescribed 6mg burprenorphine daily but was administered 3x8/ng buprenorphine/naloxone. This was not noted until 22:00hrs.			for all ward staff • Refresher courses on medicines management for senior staff to be completed • Action plan to be put in place following increased medication incidents on this ward
24/10/2016 (Incident number 122997) On checking controlled drugs medication, the count was down by 1x lorazepam tablet.	4	24/10/2016	• Staff reminders sent and management are aware of small scale discrepancies. • Pharmacy will continue to monitor for trends. **Closed from Accountable Officer's perspective** **CLOSED**
19/10/2016 (Incident number 123003) Chlodiazepoxide reducing regime, which had been prescribed originally, required changing to a lorazepam reducing regime. Doctor could not do this due to issues with the JAC system.	4	24/10/2016	• Flow chart has been made on how to discontinue a protocol • Issues with JAC protocol has been raised – expected to be resolved by next JAC upgrade **Closed from Accountable Officer's perspective** **CLOSED**
19/10/2016 (Incident number 123007) Methadone x6 bottles, buprenorphine and nitrazepam found in the safe in middle floor reception. Also, following a mock CQC inspection the previous week, other patient medication was found in the stationery cupboard.	2	24/10/2016	• All medication was signed into the medicines return book and taken to the community chemist for disposal
24/10/2016 (Incident number 123039) Message received at service to notify that no script had been left at the chemist for a client. A new script was produced to cover the client for 2 days until his next appointment.	2	25/10/2016	• Ongoing investigation
21/10/2016 (Incident number 123057) Staff nurse noted that 2x5mg diazepam tablets were missing when auditing the benzodiazepines.	4	26/10/2016	• Medicines administration assessment undertaken by staff member

26/10/2016 (Incident number 123074) Medicines administration assessment undertaken by staff member	2	27/10/2016	• Service are keeping a record to identify trends relating to this particular pharmacy
27/10/2016 (Incident number 123098) A client's prescription starting 26/10/2016 for methadone didn't arrive at the chemist resulting in the client missing one day's supply.	2	27/10/2016	• Ongoing investigation
27/10/2016 (Incident number 123106) Community pharmacy advised the service that they had administered 6x8mg suboxone instead of 2x8mg suboxone. The mistake was quickly rectified and the patient spat out the excess medication.	3	27/10/2016	• No actions identified from the service. **Closed from Accountable Officer's perspective** **CLOSED**
26/10/2016 (Incident number 123108) Community pharmacy contacted the service to notify that they were missing some prescriptions for one of our clients. 3 prescriptions had been generated for the client, each lasting 14 days. The pharmacy reported to not have the first 2 of the 3 prescriptions.	2	27/10/2016	• Log kept of prescription issues and themes to be discussed periodically at governance • Admin manager to liaise with admin scripting staff regarding vigilance when preparing prescriptions for posting
27/10/2016 (Incident number 123118) When being changed for bed, a client was observed to have what was presumed to be two pain patches on their body. These were both removed and disposed of.	3	27/10/2016	• Management reminding nursing staff to conduct full check of upper body, locate and remove previous patch before administering next patch Patch dates placed in ward diary as reminders
01/11/2016 (Incident number 123240) Ward ordered methadone for a client who was to be admitted to the ward from the acute hospital, this was done pre-emptively before	2	02/11/2016	• Ongoing investigation

the client was formally admitted to the ward. As the client was not currently admitted, Pharmacy was unable to supply the methadone.			
04/11/2016 (Incident number 123296) Upon checking a clients medication, staff member could no find a form to show that the clients medication had been counted and checked in. Also 10mg clobazam tablets had not been put into the controlled drugs cupboard	4	04/11/2016	• Isolated incident due to transfer- no further actions required as service has closed. **Closed from Accountable Officer's perspective** **CLOSED**
03/11/2016 (Incident number 123302) Request received for methylphenidate immediate release was received in Pharmacy. However, slow release was dispensed by mistake	2	04/11/2016	• Ongoing investigation
122691 (Incident number 11/10/2016) When completing benzodiazepine count, found 3x 500mcg clonazepam missing.	4		• Ongoing investigation
19/10/2016 (Incident number 122938) Service was contacted by GP surgery regarding a prescription which read once off temazepam 10mg tablets. 20mg 1 hour prior to transfer to new accommodation.	4		• Ongoing investigation
19/10/2016 (Incident number 123007) Methadone x6 bottles, buprenorphine and nitrazepam found in the safe in middle floor reception. Also, following a mock CQC inspection the previous week, other patient medication was found in the stationery	2&4		• All medication was signed into the medicines return book and taken to the community chemist for disposal

cupboard.			
122953 **(Incident number 22/10/2016)** 7.5mg zopiclone was administered to a client in error instead of 3.75mg.	4		• Ongoing investigation
23/10/2016 (Incident number 123305**)** Staff gave client 2mg diazepam instead of 4mg as prescribed.	4		Ongoing investigation
27/10/2016 (Incident number 123098**)** A client's prescription starting 26/10/2016 for methadone didn't arrive at the chemist resulting in the client missing one day's supply.	2		• Ongoing investigation
04/11/2016 (Incident number 123296) Upon checking a clients medication, staff member could no find a form to show that the clients medication had been counted and checked in. Also 10mg clobazam tablets had not been put into the controlled drugs cupboard	4		• Ongoing investigation
04/11/2016 (Incident number 123316) Zopiclone 7.5mg tablet unaccounted for on nightly check.			• Continue with daily stock checks • Nurses to remain vigilant with recording benzodiazepine administration and wastage **Closed from Accountable Officer's perspective** **CLOSED**
05/11/2016 (Incident number 123325) Clients matrifen patch was not in situ when checked. New patch was applied.	3		• Staff to continue checks every shift and conduct full searches for missing patches to reduce possible harm to patients
06/11/2016 (Incident number 123331) It was noted that there was 1x3.75mg zopiclone missing during the stock count.	4		• Ongoing investigation
07/11/2016 (Incident number 123354)	4		• Ongoing investigation

During nightly stock check it was noted that 1x7.5mg zopiclone was not accounted for.			
07/11/2016 (Incident number 123357) Clients methadone was recorded on two pages and it did not highlight that it was a sugar free solution in the book.	2		• CD training planned with nurses to highlight differences between versions of methadone, stock check and documentation • Discussed in ward meeting **Closed from Accountable Officer's perspective** **CLOSED**
07/11/2016 (Incident number 123377) Service contacted by the chemist to say that there was no dosage on the prescription for temazepam 10mg. They also needed clarification on dosages of risperidone and promethazine.	4		• Issue reviewed with Prescriber.
07/11/2016 (Incident number 123383) When doing benzodiazepine check, found clonazepam was less 1x500mcg tablet.	4		• Ongoing investigation
08/11/2016 (Incident number 123413) When nursing staff when to apply a clients matrifen patch, they couldn't find the old patch which was supposed to be on the back.	3		• Pharmacy advice has been given on micropore tape and placing patch towards the centre of back to prevent tampering • Known trend of incidents with this client
08/11/2016 (Incident number 123424) Staff member dropped a vial of lorazepam which smashed on the floor. It was cleaned up and disposed of.	4		Ampoule cutter sent to the unit to help prevent injury to staff opening ampoules but have since reported that it is difficult to use and this was a isolated incident of an ampoule smashing **Closed from Accountable Officer's perspective** **CLOSED**
08/11/2016 (Incident number 123428) 1xchlordiaxepoxide tablet was unaccounted for whilst completing the benzodiazepine check.	4		Ongoing investigation

11/11/2016 (Incident number 123631) Stock check identified 1x5mg diazepam tablet missing.	4		Ongoing investigation
12/11/2016 (Incident number 123524) Client requested prn medication. Maximum dose has been administered in the last 24 hours (6mg). PRN was administered by night staff and documented in their notes as administered but not recorded.	4		• Ongoing investigation
13/11/2016 (Incident number 123541) During benzodiazepine check, 2x5mg diazepam were unaccounted for.	4		• Ongoing investigation
14/11/2016 (Incident number 123558) Benzodiazepine check found the following unaccounted for: 1x5mg diazepam 1x1mg lorazepam 1x10mg chlordiazepoxide	4		• Ongoing investigation
14/11/2016 (Incident number 123561) Having measured out 140ml dose of methadone from two bottles, the total balance remaining should have been 100mls between the bottles but there was more that recorded in the book.	2		• CD training planned for nursing staff on this ward – topics to include liquid overages, different methadones and stock checks • Not viewed as an incident but raised training points to be addressed **Closed from Accountable Officer's perspective** **CLOSED**
15/11/2016 (Incident number 123598) 2x500mcg clonazepam were found missing during stock count.	4		• Ongoing investigation
15/11/2016 (Incident number 123626) Possible drug recording omission. 2x500mcg clonazepam tablets had not been recorded in the	4		• Ongoing investigation

ward controlled drugs book. Investigation revealed drug chart recording that patient was sleeping. No evidence on whether the tablets had been disposed of.			
16/11/2016 (Incident number 123653) Benzodiazepine recording error of service users leave medication.	4		• Ongoing investigation
17/11/2016 (Incident number 123675) When changing Matrifen patch 12mcg it was apparent that the previous patch applied on 14th had become unattached. Further patch applied today as per prescription.	3		• Staff to check client's patches every shift (where possible) • Advised to use micropore tape to help adhesion and encourage through checking of bedding and room for the patch • Patch suitability has been discussed with the client's GP and alternatives have been considered but were deemed inappropriate
22/11/2016 (Incident number 123781) Patient was seen by duty doctor who prescribed lorazepam 1mg. Patient does not have T2/T3 as she is not prescribed psychotropic medication nor section 62 to account for lorazepam prescribing.	4		• Ongoing investigation
22/11/2016 (Incident number 123800) Benzodiazepine stock check noted it was down by 1x10mg diazepam.	4		• Ongoing investigation
22/11/2016 (Incident number 123850) Support worker reported that there were 8 codeine tablets missing from a clients recently replenished supply of medication.	5		• Ongoing investigation
22/11/2016 (Incident number 123814) Client was found in home having taken an overdose. An ambulance was called and the client was taken to A&E.			• Ongoing investigation
22/12/2016 (Incident number 124625)	4		• Ongoing investigation

Lorazepam 1mg tablets were down by 15 dose units on the daily check.			
25/11/2016 (Incident number 123860) Service received a call from a client's father reporting that the client had taken two days of methadone (55mg each day totalling 110mg).	2		• Client was reviewed by the consultant • Supervision of prescription was increased
25/11/2016 (Incident number 124022) Following a reported high temperature of the clinic room fridge, it was decided that the ampoules of lorazepam should be returned to Pharmacy. This was not recorded in the CD stock book. Also, after a Pharmacy audit, the discarded lorazepam were still on the 'return to Pharmacy' shelf.	4		• Training attended by nurse involved • Fridge has been checked for faults and no issues reported • No issues picked up during most recent top-up by technicians
29/11/2016 (Incident number 123955) Administration of 2mg diazepam was not signed for in the controlled drugs record book.	4		• Ongoing investigation
29/11/2016 (Incident number 124053) Client had been given a holiday script to cover while they were in Thailand. While in Thailand, the client reports that the medication was stolen. 32x50mg amps and 1200mg methadone (5mg tablets) plus 16 days of nitrazepam 20mg daily.	2&4		• Treatment re-started and dispensed in daily instalments • Process started for transferring to a drug treatment centre elsewhere
30/11/2016 (Incident number 123982) SOP check: 1x1mg lorazepam missing.	4		• Ongoing investigation
30/11/2016 (Incident number 123997) Patient was asleep during lunchtime medication round and when awakened, refused his	4		• Ongoing investigation

medication which includes 500mcgs clonazepam. He later suffered from a seizure and was administered buccal midazolam 10mgs/1ml.			
30/11/2016 (Incident number 124005) Benzodiazepine count was down by 1x10mg diazepam.	4		• Ongoing investigation
01/12/2016 (Incident number 124049) During ward top-up by the pharmacy technician, ward staff were informed that 7x2mg diazepam tablets had been placed in the wrong box. The batch numbers did not match and would therefore need discarding and the expiry date would be wrong.	4		• Nurses reminded to order stock appropriately and return unused medication to Pharmacy • Team meeting arranged to discuss incident and further remind staff to check batch numbers and expiry dates **Closed from Accountable Officer's perspective** **CLOSED**
03/12/2016 (Incident number 124071) Whilst completing drugs check as per SOP, unable to locate the key to the controlled drugs cupboard.			• Ongoing investigation
03/12/2016 (Incident number 124074) Nurse checked on a client's pain patch and found that it was on the bedding and not on the client. The client appeared not to be in pain.	3		• Daily patch checks in place and recorded on Insight
03/12/2016 (Incident number 124085) SOP benzodiazepine check showed 1x4mg/1ml lorazepam ampoule not accounted for.	4		• Ongoing investigation
05/12/2016 (Incident number 124114) Patient requested and was given 2mg diazepam. Prescription was for 2mg every twelve hours with maximum of 2mg in 24 hour period. This meant that the patient received	4		• Ongoing investigation

4mg in a 24 hour period.			
10/12/2016 (Incident number 124262) Patient was observed taking their medication and staff were confident that she had swallowed the tablets. A member of staff later reported that they had found a tablet on the floor of this patients room (described as 2mg diazepam) and when they asked the patient, she snatched it out of their hand and took it.	4		• Staff reminded to encourage the patient to attend the clinic room for medication so staff can ensure no medication is hidden in her room • Team aware of possible stockpiling of medication and will check carefully at each administration the patient has taken all the tablets **Closed from Accountable Officer's perspective** • **CLOSED**
11/12/2016 (Incident number 124278) Client was administered sugar free methadone instead of their prescribed regular methadone. Linked to incident 124280	2		• CD training planned for nursing staff • Nursing staff have been reminded to be vigilant with giving methadone and checking the prescription carefully General lack of knowledge regarding sugar free and normal methadone is being addressed in training **Closed from Accountable Officer's perspective** • **CLOSED**
11/12/2016 (Incident number 124280) Client was administered regular methadone instead of their prescribed sugar free methadone. Linked to incident 124278	2		• CD training planned for nursing staff • Nursing staff have been reminded to be vigilant with giving methadone and checking the prescription carefully • General lack of knowledge regarding sugar free and normal methadone is being addressed in training **Closed from Accountable Officer's perspective** • **CLOSED**
13/12/2016 (Incident number 124342) 1x5mg diazepam tablets was found missing during stock check	4		• Ongoing investigation
13/12/2016 (Incident number 124366) Staff found a client with several pain patches on his back and shoulders: 2 c 10mcg & 3 x 5mg.	3		• Ongoing investigation
16/12/2016 (Incident number 124453) Service informed of a client who had taken an overdose of 5 temazepam	4		• Ongoing investigation

tablets.			
13/12/2016 (Incident number 124343) 2xlorazepam tablets found missing during benzodiazepine stock check.	4		• Ongoing investigation
18/12/2016 (Incident number 124476) 2x2mg diazepam tablets were unaccounted for during stock check.	4		• Ongoing investigation
21/12/2016 (Incident number 124573) Client contacted the service to say they had been given another client's prescription in error. Client agreed to post them back to the service.	2		• New prescriptions generated and posted to client • Staff attempted to contact the client regarding confidentiality • Posting and admin process to be reviewed as part of the incident review
24/12/2016 (Incident number 124724) Patient returned from NGH with discharge medication including a controlled drug. When night staff came on duty they realised that the controlled drug had not been documented or stored properly	2		• Ongoing investigation
27/12/2016 (Incident number 124711) During contact with client, she stated that she'd taken an overdose the previous night: 2 weeks worth of medication plus 8 lorazepam tablets.	4		• Ongoing investigation
27/12/2016 (Incident number 124681) 1x10mg temazepam tablet was found missing during stock check.	4		• Ongoing investigation
29/12/2016 (Incident number 124719) Client attended the service to report that there was no prescription at the chemist. The chemist was contacted and they reported they didn't have it. This prescription had been	2		• Prescription was re-printed and handed to client • Posting of prescriptions to be reviewed

stapled together with other previous prescriptions and sent to the chemist.			
29/12/2016 (Incident number 124732) Service use was found to not have a pain patch in situ when the new one was applied.	3		• Continuing patch checks every shift and to use micropore to secure patch closer to the centre of the back to avoid removal by client • Continued vigilance by the nursing team
30/12/2016 (Incident number 124740) Client's pain patch was checked AM and was in situ, however it was noticed that there were two patches. Old patch appears to have not been removed.	3		• Ongoing investigation
Incident number:124849 **04/01/17** Patient was administered 1mg lorazepam prn at 17:00hrs but this wasn't charted on JAC. A further 1mg lorazepam prn was then administered at 18:22.	4	04/01/2017	• Management have reminded staff not to check JAC in the office but to check in the clinic room prior to administration as per SOP. Signs have also been put up to alert staff to chart administration. **Closed from Accountable Officer's perspective** **CLOSED**
Incident number: 124887 **04/01/17** Resident was found without pain patch on.	2	04/01/2017	• Brand of fentanyl patches changed from Matrifen to Durogesic (test if adhesion better). Staff reminded again regarding patch checks per shift and filling in chart.
Incident number: 124914 **05/01/17** Box of clonazepam containing 50 tablets was recorded as being received from Pharmacy as 100 tablets.	4	06/0+1/2017	• Planned action from ward management to remind nurses of the procedures. **Closed from Accountable Officer's perspective** **CLOSED**
Incident number: 124923 **06/01/17** Discharge prescription was initially sent to the ward with regular medication on it; then methadone and diazepam added later as patient was unable to go to	4	19/01/17	• No known trend of dispensing / accuracy checking errors. Staff involved have reviewed the incident with senior staff.

out-patient service due to mobility. Methadone and codeine dispensed but diazepam wasn't.			
Incident number: 124926 **06/01/17** Client collapsed in the reception area. Reported to have taken 10x300mg pregabalin plus diazepam, £60 heroin and alcohol. Staff attempted to administer naloxone IM but difficult due to patient agitation and risk of needle stick injury. Oxygen SATS dropped - oxygen 100% administered. BLS protocol followed. Ambulance called but client refused to travel then left the building. Deemed to be capacitous by ambulance crew. Police were called.	4	15/02/2017	• Illicit use by patient.
Incident number: 124960 **07/01/17** Discrepancy in the tablet count. CD book said there should be 23x1mg tablets but there were only 22.	4	09/01/17	• The clinic room is also the nurses office where there is potential for distraction. Small scale discrepancy.
Incident number: 125040 **06/01/17** Staff member arrived at work to find a carrier bag of medicines on their desk and assumed they were for disposal. Unknown where they came from. Pharmacy contacted and taken to them for identification and disposal	4	11/01/17	• It is unclear where the medication came from but appropriate actions were taken for safe disposal. **Closed from Accountable Officer's perspective** **CLOSED**
Incident number: 125042 **10/01/17** Patient admitted to ward and brought in their own supply of fentanyl 100mcg patches (9 in total). One patch is believed to have been administered and the remainder sent to Pharmacy for destruction. However, the patient's husband requested the patches were returned to the patient.	2	11/01/18	• Communications and explanations should be given when medication is taken from service users. Incident has been reviewed and shared with carers. **Closed from Accountable Officer's perspective** **CLOSED**
Incident number: 125098	2	13/01/18	• Shared with ccg accountable

09/01/17 Service user DNA multiple appointments. At last DNA script pick-up and supervision increased to 3 supervised pick-ups with a review following week. Pharmacy contacted to check script compliance and advised the following: 06/01/17 – script collected but record of it being supervised 09/01/17 – collected by wife (pharmacy error) 11/01/17 – no collection			officer.
Incident number: 125111 **12/01/17** Wrong strength of medication given; 8/500 co-codamol given instead of 15/500. 10mg temazepam was not offered.	3	16/01/17	• Unable to follow up with action plan now the service has closed. **Closed from Accountable Officer's perspective** **CLOSED**
Incident number: 125200 **16/01/17** Client was admitted to intensive care with an overdose and was reported to have died.	2	18/01/2017	• Suspected overdose. • Awaiting reports and decision if inquest to be opened.
Incident number: 125317 **20/01/17** During routine CD stock check the following issues were noted: 1.Clonazepam -2x500mcg 2.Midazolam 10mg/2mls stated just 8 but unclear is this meant 8mls or 8 syringes New CD book dose of rectal diazepam said 10mg but should have said 5mg	3&4	23/01/17	• JAC implementation may speed up reconciliation of missing tablets with administration records. However, staff reminded to record clearly on benzodiazepine book to avoid confusion. Transfer of stock balance into new CD register can be checked by a second member of staff to prevent transcription errors.
Incident number: 125322 **21/01/17** Benzodiazepine check showed lorazepam 1mg was down by 2 tablets. One tablet was later accounted for.	4	23/01/17	• Small discrepancy. No concern/trend identified.

Incident number: 125334 **21/01/17** Signature missing for administration of clonazepam. After further investigation staff member realised that the medication had not been given.	4	23/01/17	• Ideally, two nurses are present during a shift and management to encourage protected time for medication administration to prevent errors. JAC implementation should prevent missed doses. Pharmacy to monitor for further incidents.
Incident number: 125344 **22/01/17** Patient A disclosed to staff that she had secreted her morning dose of clonazepam (1000mcg), crushed it up, placed it into a roll-up along with tobacco and gave it to patient B to smoke. The other patient had already received their morning dose of clonazepam which means they could have potentially consumed 2mg clonazepam.	4	24/01/17	• Patient A was transferred to another ward due to escalating risks and behaviour.
Incident number: 125346 **22/01/17** Resident was found without his pain patch on.	2	23/01/17	• Staff to continue patch checks per shift.
Incident number: 125388 **23/01/17** Staff member administered 7.5mg zopiclone to a patient before realising that it had already been administered.	4	24/01/17	• No previous medicines incidents identified on the Safeguard system. To monitor for further incidents.
Incident number: 125395 **21/01/17** Patient was prescribed diazepam 5mg one hourly when necessary – 15 tablets prescribed by the GP collaborative. Service telephoned the patient's husband to review and was told that he'd given his wife 7x5mg diazepam.	4	02/02/17	• Clear communication with client's carer should be encouraged to avoid confusion with medication Team to review in monthly governance meeting. • Shared with CCG
Incident number: 125440 **25/01/17** Daily stock check completed. Stock levels should have been 148 dose	3	25/01/2017	• Tramadol has been added to the weekly stock checks (undertaken on a Tuesday). This is handwritten on to the stock check list sheet (no capacity to add new drugs – only 10 drugs able to be added to the

units but there were only 97 on the shelf showing a discrepancy of 51 dose units			KTAKE report). • Two incidents in Pharmacy identified in Dec/Jan but no wider trend/concern identified. **Closed from Accountable Officer's perspective** **CLOSED**
Incident number: 125446 **26/01/17** Stock check showed there was minus 1x500mcg clonazepam.	4	26/01/17	• Small scale discrepancy. No further actions required. **Closed from Accountable Officer's perspective** **CLOSED**
Incident number: 125454 **25/01/17** Patient was given 1mg lorazepam but this was not charted on JAC.	4	27/01/17	• Procedure not followed.
Incident number: 125475 **26/01/17** During benzodiazepine check it was noted that 1x10mg diazepam tablet was unaccounted for.	4	27/01/17	• Nurse management completed incident review. Underlying causes suggested as failure to record any refused, dropped and disposed medication. Plan from management is to remind staff of procedures for recording refused, dropped and disposed medication.
Incident number: 125487 **27/01/17** Patient attended the community service with his father and was not seen and advised to go to A&E. Father took him to the Longley Centre and, after staff contacted the service, advised that should return to the community service. Unwilling to do so, the doctor agreed to go to Longley Centre. Police assistance was required and remained throughout the assessment. Doctor prescribed 1mg lorazepam on a green prescription. Pharmacy was consulted and medication was taken from an inpatient ward (this is out of policy).	4	27/01/17	• No relevant actions identified in the circumstances presented. Staff were in a difficult situation as immediate actions were needed to de-escalate the situation. Ward was able to facilitate the request for lorazepam in a timely manner. **Closed from Accountable Officer's perspective** **CLOSED**
Incident number: 125523 **29/01/17** When staff went to change the pain patch for a client,	2	30/01/17	• Know issues with patch adhesive. If further incidents occur, a switching to a different brand to be considered.

the old patch could not be found.			• Ongoing investigation
Incident number: 125576 **01/02/17** During night stock check of controlled drugs, a full measurement of liquid clonazepam was taken as opposed to a visual only check. As a result of this check, the clonazepam was at 240ml as opposed to the documented 260ml.	4	01/02/17	• Continue routine benzodiazepine checks as per SOP. • Ongoing investigation
Incident number: 125620 **02/02/17** Community pharmacist dispensed 7 days of methadone instead of 4 days. They have been unable to contact the client to discuss.	2	15/02/17	No relevant actions identified within the Trust. **Closed from Accountable Officer's perspective** **CLOSED**
Incident number: 125642 **01/02/17** Service received a phone call from the community pharmacy requesting to replace a lost prescription for buprenorphine 200mcg x2 tablets daily, prescription date 01/02/17, 03/02/17, 17/02/17 & 03/03/17 not at the pharmacy. All scripts were printed 25/01/17 so should have been posted and arrived by now.	2	15/02/17	• Risks of posting prescriptions.
Incident number: 125677 and 125686 **04/02/17** Diazepam 5mg tablets were down by one tablet but diazepam 2mg tablets were one over. Suggesting that in the last 24 hour period a 5md diazepam tablet had been administered instead of a 2mg in error.	4	06/02/17	• Staff member only realised their error the day after the incident when other staff noted a discrepancy during the benzodiazepine check • Ongoing investigation
Incident number: 125791 **08/02/17** Client's wife found his	2	10/02/17	• Increased patch checks to 3 times daily. GP has changed patches to Durogesic brand to check if

fentanyl patch on the floor of his room and handed it to a member of staff.			adhesion is better. • Ongoing investigation
Incident number: 125907 **26/06/2016** Incident logged retrospectively following findings from the CQC review in Nov 2016. It was identified that a patient received rapid tranquilisation involving IM lorazepam but was not monitored post rapid tranquilisation.	4	14/02/17	• As rapid tranquilisation is rarely used at this unit, management has reminded all nurses of actions to take following rapid tranquilisation and discussed the incident with staff. • Ongoing investigation
Incident number: 125936 **15/02/17** Service user was recently transferred from one of the adult wards. Had been prescribed zopiclone but this was not on the T3.	4	15/02/17	• Team reminded to check T3's against prescriptions. Other wards may want to consider reviewing procedures for checking T2 & T3 to ensure legal regulations are met.
Incident number: 125991 **17/02/17** Having already been administered prn haloperidol 5mg and prn promethazine 25mg at 10:40hrs, client was administered prn clonazepam 1mg at 11:55hrs instead of regular dose of clonazepam liquid 1mg/10mls	4	20/02/17	• Staff nurses to be vigilant when giving prns and should be mindful of when regular medication is due to be charted. • Management to discuss idea of no distraction during medicines round with reception staff to minimise disruptions. • JAC has been implemented at Firshill Rise- staff should continue to be vigilant with new system of working.
Incident number: 126090 **21/02/17** Shortfall in the stock balance of clonazepam liquid. There should have been 365mls but 5ml was unaccounted for in one of the bottles.	4	21/02/17	• Consider bottle stops for clonazepam and diazepam liquids • Continue monitoring discrepancies
Incident number: 126116 **22/02/17** Community pharmacy telephoned the service	2	24/02/17	• Waiting for implementation date of near patient dispensing.

saying they hadn't got a script dated 24/02/17 for methadone for a particular client and asked for a reprint.			
Incident number: 126131 **23/02/17** On counting the midazolam there was only 11 when the stock value for midazolam was 12 in the controlled drug book.	3	23/02/17	• Nurses have been reminded that they can chart medication as 'administered by other healthcare professional'. Management have clarified with community pharmacy whether on duty nurse can sign off on administration via syringe driver. **Closed from Accountable Officer's perspective** **CLOSED**
Incident number: 126135 **23/02/17** Clonazepam stock check down by 1x tablet. Visual check of liquid diazepam also down by approx 15ml.	4	23/02/17	• No further investigation required. Continue with benzodiazepine stock checks as per policy. **Closed from Accountable Officer's perspective** **CLOSED**
Incident number: 126206 **24/02/17** Leave medication was delivered to the ward in 2 separate bags for two separate overnight leaves. Each bag containing 20mg olanzapine, 20mg fluoxetine and 50mls methadone. There wasn't the paper discharge leave prescription sent back with these.	2	27/02/17	• Ward did not request copy of controlled drug prescription to be given to them. Advised ward to take copy of prescription before giving original to pharmacy for dispensing. **Closed from Accountable Officer's perspective** **CLOSED**
Incident number: 126207 **25/02/17** Client's pain patch was checked by staff but they were unable to find it on his body.	2	27/02/17	• Unit is currently reviewing patch incidents due to recent trend. Staff to consider Duragesic brand if incidents continue. Staff to continue checking room and laundry thoroughly if patches are missing.
Incident number: 126262 **28/02/17** Patient called the service stating they had gone to the chemist to collect their methadone. Should have collected 5x5mgs diazepam and 2mg diazepam x1 per day for 7 days. When arrived home, did not have any diazepam 2mg but buprenorphine 2mg x7. When checked on Insight,	2	28/02/17	• Unit advised client to return buprenorphine and informed consultant and admin team of error.

the prescription did say buprenorphine but no rationale in notes as the patient doesn't take opiates.			
Incident number: 126282 **01/03/17** It was noted that during the 17:00hrs medication round that a client had not been given their lunch time medication.	4	02/03/17	• Management plan includes staff to check JAC at beginning of their shift, look in control book to see what time their last medication was administered.
Incident number: 126304 **02/03/17** Service user was checked for pain patch in situ but staff were unable to find it'	2	06/03/17	• Known trend of patch incidents at this unit. Management has changed to chest area as this was the site previously due to patches coming off. GP has changed patch to Duragesic brand. **Closed from Accountable Officer's perspective** **CLOSED**
Incident number: 126332 **04/03/17** On benzodiazepine check noted that clonazepam 500mcg was one down.	4	06/03/17	• Continue to monitor small scale discrepancies by investigators. Consider quarterly checks on discrepancies to identify checks. **Closed from Accountable Officer's perspective** **CLOSED**
Incident number: 126530 **14/03/17** -On completing nightly benzodiazepine stock check it was noted that the stock of 1mg lorazepam tablets appears incorrect, with 1 tablet unaccounted for in the record book.	4	22/03/17	• Small scale discrepancy – no further investigation. No identified trend of incidents with benzodiazepine discrepancies. **Closed from Accountable Officer's perspective** **CLOSED**
Incident number: 126752 **24/03/17** On routine count 4x500mcg clonazepam tablets were unaccounted for.	4	24/03/17	• No further investigation needed. Report of recent incidents to be attached to log to identify trends.
Incident number: 126797 **25/03/17** Stock balance showed that there was 1x1mg lorazepam tablet missing during stock count. Investigation found that 1mg lorazepam had been given the night before but wasn't recorded in the book.	4	27/03/17	• Continue benzodiazepine checks as per local procedures. Nurses reminded to record administrations in benzodiazepines book.

Incident number: 126813 **27/07/17** Service received telephone call from client's husband. Believes he accidentally gave the client 6x1mg lorazepam tablets and that she is currently fast asleep and unrousable. Was advised to call 999.	4	27/03/17	• Community services to remain in contact with social services and liaise with them regarding discharge. • Safeguarding to be captured in the future. (client deceased June 17)
Incident number: 126362 **06/03/17** On stock check of benzodiazepine it was noted that clonazepam 2mg was one tablet up on running record of stock and clonazepam 0.5mg was one tablet down.	4	06/03/17	• Continue monitoring of discrepancies. If trend apparent, management to be informed again and discuss plan.
22/01/2016 **(Incident number 116689)** Death of client. Cause of death was due to a combination of lung disease and drug toxicity.		08/03/2017	• No further actions/concerns identified by the Coroner's review. • Severe physical health problems and ongoing substance misuse.
29/01/2016 **(Incident number 117105)** Death of client. Cause of death was aspiration of gastric contents and methadone, morphine, amphetamine, diazepam & cannabis use. Drug related death.		08/03/2017	• No specific actions identified. • Illicit drug related death.
19/09/2016 **(Incident number 120535)** Death of client. Cause of death was opiate toxicity + acute alcohol intoxication. Drug related death		03/03/2017	• No actions identified from the Coroner's inquest for the Trust. **Closed from Accountable Officer's perspective** **CLOSED**
19/09/2016 **(Incident number 122208)** Trust informed by Coroner's office that client had passed away. Coroner's inquest outcome:		25/01/2017	• No prescribing concerns identified within the Trust. • Drug related death.

Cause of death – 1a) heroin toxicity & use of diazepam, diahydra-codine & cocaine Conclusion: drug related death			
25/01/2016 **(Incident number 125440)** Daily stock check showed that the levels were wrong for tramadol 50mg capsules. JAC system stated 148 dose units but there were only 97 on the shelf, showing a discrepancy of 51 dose units.		25/01/2017	• Further consideration to be given to the monitoring of other tramadol preparations in the department. **Closed from Accountable Officer's perspective** **CLOSED**
13/02/2017 **(Incident number 125900)** Staff member was to deliver a prescription to a service user's home address but after posting it through the letterbox realised it was the wrong letter box.	4	04/04/2017	Encourage vigilance in home treatment team when delivering prescriptions. • This was not routine practice as patients are usually seen by staff.
24/03/2017 **(Incident number 126752)** Routine count found 4x500mcg clonazepam tablets unaccounted for.	4	03/04/2017	• No further actions required.
27/03/2017 **(Incident number 126813)** Service was contacted by client's husband. Informed that he believes he's accidentally given his wife 6x1mg tablets of lorazepam and was currently asleep and was unable to rouse her. He was advised to ring 999 and request an ambulance.	4	27/03/2017	• Service to continue liaising with adult social care regarding client and their carer.
30/03/2017 **(Incident number 126856)** During nightly benzodiazepine stock count, 2x500mcg clonazepam tablets were unaccounted for.	4	30/03/2017	• Medicines Safety Officer visited ward to discuss incidents – reminder for staff to log wasted/refused benzodiazepines.
30/03/2017 **(Incident number 126865)** Service user contacted the office around 10am	4	10/04/2017	• No further actions required by Pharmacy. • Team to review death.

reporting that they had taken an overdose of 40 clonazepam. They had contacted an ambulance after vomiting a couple of hours later but refused treatment.			
02/04/2017 **(Incident number 126936)** Upon nightly check of benzodiazepines, lorazepam 1mg were found to be 1 down.	4	03/04/2017	• Ward to continue with daily benzodiazepine checks and following SOP to search for discrepancies. Small scale discrepancy, no further action required. **Closed from Accountable Officer's perspective** **CLOSED**
02/04/2017 **(Incident number 126967)** Client reported suicide attempt by overdose of ketamin, MDMA and benzodiazepines (not prescribed). Specific times or quantities not specified.	Illicit	03/04/2017	• Extra vigilance needed. Risk of severe harm or fatality remains high due to self harming behaviour. **Closed from Accountable Officer's perspective** **CLOSED**
09/04/2017 **(Incident number 127174)** Benzodiazepine check was not done due to clinical activity on the ward. Only 2 qualified on the ward at the time.		09/05/2017	• Ward pharmacist writing guidance document to remind nurses to complete SOP benzodiazepine checks and logging wasted/refused benzodiazepines. Incident discussed in ward governance.
10/04/2017 **(Incident number** 127249) When doing benzodiazepine check, staff member found that there was 1x1mg lorazepam missing.	4	12/04/2017	• No further actions needed. **Closed from Accountable Officer's perspective** **CLOSED**
11/04/2017 **(Incident number 127703)** Client attended the service stating there wasn't a prescription for them at the chemist. On checking, a prescription was produced and sent to the chemist.	2	28/03/2017	• Ongoing investigation
12/04/2017 **(Incident number 127291)** Patient was 'off script' after missing 3 clinical appointments.	2	13/04/2017	• Ongoing investigation

13/04/2017 **(Incident number** 127301) Service received telephone call from patient saying they didn't have a prescription for their methadone. When checked, a prescription was sent to the chemist. A new prescription was generated.	2	13/04/2017	• Ongoing investigation
14/04/2017 **(Incident number** 127325) Staff member found 1x box of 10mg temazepam and 3x boxes of 5mg diazepam placed in a plastic back at the back of the drug cupboard – these had not been signed into the controlled drugs book. Also found that 1x dose of 5mg on 13/04/2017 at 7pm which was not countersigned in the CD book.	3&4	14/04/2017	• To be escalated with. ward management
14/04/2017 **(Incident number** 127333) 2x5mg diazepam were missing during stock count.	4	14/04/2017	• Staff advised to ensure clinic room doors are locked at all times when not being used. Pharmacy stock checks to include checking controlled stationery is stored securely / in locked clinic room.
17/04/2017 **(Incident number** 127409) Staff member administered 2mg diazepam to a patient after discussing with the on-call medic as the patient requested prn medication. After completing the medication round the staff member noticed that this patient had already received their regular dose of 2mg diazepam.	4	18/04/2017	• Up to date training being offered to staff members involved in incident.
19/04/2017 **(Incident number**127457) A patient's discharge medication of 70x5mg diazepam tablets was sent to the ward. On reviewing the prescription it appears that 28 days was prescribed (56 tablets) and 14 days worth of PRN (14 tablets). Staff gave 42 tablets due to it being a 14	4	19/04/2017	• Pharmacist clinical check SOP still relevant. Incident learning to be shared in pharmacists clinical meetings.

day supply of both medication.			
20/04/2017 **(Incident number** 127487) Patient was administered a dose of 5mg diazepam at 10.52hrs and then a further dose at 13.00hrs.	4	20/04/2017	• Ward management aware of incident and due to complete a management report.
21/04/2017 **(Incident number** 127502) Lorazepam ampoules destroyed due to increase in fridge temperature.	4	21/04/2017	• No consistent trend of fridge incidents identified throughout year but Pharmacy monitoring of temperatures continue. Ward pharmacist to discuss in governance.
21/04/2017 **(Incident number** 127514) Due to fridge temperatures being out of range,13x IM lorazepam 4mg/1ml had been taken out for return to Pharmacy. A new delivery of 10 ampoules were then placed in the fridge. This medication was not recorded in the benzodiazepine control book.	4	24/04/2017	• Ongoing investigation
22/04/2017 **(Incident number** 127537) During daily benzodiazepine check it was noted that there was 1x3.75mg zopiclone tablet missing.	4	24/04/2017	• Management to ensure two registered nurses are giving and checking medication as per administration policy **Closed from Accountable Officer's perspective** **CLOSED**
23/04/2017 **(Incident number** 127549) Clonazepam 500mcg tablets balance was wrong by +2 tablets. Clonazepam 2mg tablets balance was also wrong by +2 tablets.	4	24/04/2017	• Ongoing investigation. Possible wrong administration to client. For escalation with nurse management.
23/04/2017 **(Incident number** 127572) Staff member took a patient's medication to them in the quiet lounge however they refused it, grabbed the medication tot and threw it on the floor.	4	24/04/2017	• Nurses dispensed new medication as dropped medication was not suitable for use. Care plan was reviewed
23/04/2017	4	10/05/2017	• Nurse management recognise that

(Incident number 127558) Whilst patient attended the clinic room for their medication they picked up a medicine tot containing 1mg lorazepam (which was for another patient) and took it. Patient refused to spit out the tablet.			some clients may be more opportunistic and attempt to take more medication. Extra staff during administration, asking clients to wait outside has been considered.
23/04/2017 **(Incident number** 127600) Patient was found unconscious at home by family member, having taken an overdose of morphine liquid. The medication was not the patients own but had been prescribed to her late partner. Many bottles of the medication had been removed by family and SHSC staff following her partners death however, this medication must have been forgotten about or hidden in the house.	5	25/04/2017	• Team worked with client's family to remove any extra medication after incident. Extra social care arrangements considered to help client manage at home. **Closed from Accountable Officer's perspective** **CLOSED**
25/04/2017 **(Incident number** 127616) SOP benzodiazepines check has shown lorazepam 1mg stock to be one tablet down.	4	09/05/2017	• Senior staff are monitoring incidents in governance.
28/04/2017 **(Incident number** 127667) Patient requested his medication but when staff member took the medication from the cupboard, the patient grabbed the bag from the staff member and ran off with it. When staff managed to retrieve the bag off the patient they then administered diazepam.	4	27/04/2017	• Root cause – client was struggling with emotions and needed extra support. Client was encouraged to work collaboratively with staff to manage distress and emotional regulation.
28/04/2017 **(Incident number** 127706) Client's pain patch was missing when staff checked.	2	28/04/2017	• Staff reminded of the need to log incidents for missing patches. **Closed from Accountable Officer's perspective**

			CLOSED
01/05/2017 **(Incident number** 127758) SOP check of clonazepam 500mcg showed there was a deficit of 7 tablets.	4	07/06/2017	• Awaiting further information.
01/05/2017 **(Incident number** 127764) Staff member found two instances of diazepam 5mg being written in the record book as administered but not charted on JAC.	4	07/06/2017	• Awaiting further information.
03/05/2017 **(Incident number** 127827) 1 Lorazepam 1mg missing from stock check.	4	04/05/2017	• Pharmacy has escalated this to ward governance.
03/05/2017 **(Incident number** 127904) Ward ordered methadone sugar free. Requisition signed by pharmacist and clinically checked but seems to have been interpreted as a CD check. Methadone was therefore supplied without any check of what had been dispensed by a pharmacist.	2	08/05/2017	• SOPs to be reviewed to ensure all pharmacists sign in the same section to avoid confusion. No further actions required at this time. Isolated incident – all other pharmacists aware of incident. **Closed from Accountable Officer's perspective** **CLOSED**
04/05/2017 **(Incident number** 127838) Stock count said there should be 37x5mg diazepam tablets but there were only 36.	4	05/05/2017	• Disruptions during the medication round is a known risk and ward management have obtained funding for a new clinic room separate from the nursing office.
05/05/2017 **(Incident number**127865) After receiving a delivery of lorazepam ampoules, staff noticed that the current stock was down by 2 ampoules. After checking with staff it would appear the previous night, one ampoule was faulty and disposed of and one was used, both not recorded in the book.	4	05/05/2017	• Consider check list for staff if rapid tranquilisation is used/considered. Procedure for benzodiazepines changed to daily checks to monitor administrations are recorded correctly. Management has raised the incident at team meeting to reflect on current practice.
14/05/2017	4	15/05/2017	• No further actions required. Client

(Incident number 128045) Patient reported bringing in their own supply of zopiclone 7.5mg to the ward and over the past 3 days has been self administering at least 15mg in the afternoons, then requesting another 7.5mg prn with their night time medication.			discharged from ward and back in community team.
09/05/2017 **(Incident number** 127958) Daily stock check showed that the department was two full packs of diazepam 2mg tablets	4	06/06/2017	• Awaiting further information.
14/05/2017 **(Incident number** 128045) Patient reported bringing in their own supply of zopiclone 7.5mg to the ward and over the past 3 days has been self administering at least 15mg in the afternoons, then requesting another 7.5mg prn with their night time medication.	4	15/05/2017	• Awaiting further information.
17/05/2017 **(Incident number** 128135) Service received a call from the helpline advising that a client had called stating that they had taken an overdose of diazepam. Service contacted the client who confirmed they had taken 14x15mg diazepam with suicidal intent. An ambulance was called.	4	17/05/2017	• Client's spouse is aware of overdose risk when unwell and will take responsibility for safe storage of medicines when client is unwell. Extra longer term support with mental health through the recovery team to be arranged. **Closed from Accountable Officer's perspective** **CLOSED**
17/05/2017 **(Incident number** 128191) Patient was prescribed wrong preparation of methadone on JAC system. Correct daily dose was prescribed in line with the service but this was prescribed as methadone	2	19/05/2017	• Methadone preparations are a known prescribing and administration risk. Senior staff have made the concentrate (the less commonly used preparation) non prescribable to prevent overdose potential.

concentrate 10mg/1ml. This had been administered on 2 occasions from methadone sugar free supply.			
19/05/2017 **(Incident number** 128192) Diazepam was down by 3 tablets during the count.	4	24/05/2017	• Nurse management suspect that the missing tablets may have been refused/disposed of doses. For review in governance.
19/05/2017 **(Incident number** 128194) CD stock check showed there was 1x 2mls/10mg midazolam syringe missing.	3	19/05/2017	• Management to consider ward plan for management of client's own midazolam. • Reminders for staff when a client has both stock and own supply. • Clearer documentation of when client's stock is taken out for leave and whether they were returned needed. **Closed from Accountable Officer's perspective** **CLOSED**
20/05/2017 **(Incident number** 128215) Patient snatched medication from staff causing medication to fall on the floor. Same happened again on a second attempt. Another diazepam was successfully given to the patient.	4	22/05/2017	• No further actions required.
23/05/2017 **(Incident number** 128277) 1x clonazepam tablet missing during count.	4	23/05/2017	• Busy ward environment mentioned as possible underlying cause. A missed record of administration can be due to distractions in the process. For review by ward pharmacist in next governance meeting.
26/05/2017 **(Incident number** 128379) Patient was prescribed clonazepam in liquid form. Dosage was 500 mcg (0.5 mls). Strength of liquid was 0.5mg in 5mls. The patient was given 0.5ml equal to 50mcg.	4	25/06/2017	• Reflective learning focusing on dispensing medication has been completed with ward management. **Closed from Accountable Officer's perspective** **CLOSED**
26/05/2017 **(Incident number** 128392) Medication given to patient but wasn't charted. Patient	4	12/06/2017	• Awaiting further information.

was given dose again.			
30/05/2017 **(Incident number** 128467) Service user was prescribed methadone sugar free 50mg which was administered but not charted on JAC. Staff identified this error so it was not administered twice.	2	31/05/2017	• Awaiting further information.
07/06/2017 **(Incident number** 128688) Staff member refused to provide a witness signature for administered medication as they hadn't witnessed the dispensing of it.	4	07/06/2017	• Incident discussed with nurse management who are aware that support workers should not be routinely asked to witness administration. **Closed from Accountable Officer's perspective** **CLOSED**
07/06/2017 **(Incident number** 128704) Control drugs count showed rectal diazepam was down by 2 x 5mg.	4	08/06/2017	• Discussed with technician – recording in the book is part of the SOP and this must be followed. **Closed from Accountable Officer's perspective** **CLOSED**
08/06/2017 **(Incident number** 128707) On nightly benzodiazepine check, stock count of diazepam 5mg tablets was one tablet short.	4	10/07/2017	• Awaiting further information
08/06/2017 **(Incident number** 128708) Previous incident (128707) for incorrect stock balance. Missing administration found.	4	11/072017	Awaiting further information.
15/06/2017 **(Incident number** 128884) After administering medication is was noted that there was one tablet of diazepam missing.	4	21/06/2017	• Isolated incident, ward technicians will continue to check benzodiazepine quantities. **Closed from Accountable Officer's perspective** **CLOSED**
21/06/2017 **(Incident number** 129025) Client's medication was incorrect on checking.	4	21/06/2017	Continue daily stock checks as per SOP. Incident discussed in staff meeting. • No trend of missing tablets identified.

6x1mg lorazepam tablets missing during stock check.			
22/06/2017 **(Incident number** 129060) – Noted that 2x clonazepam tablets were no accounted for.	4	22/06/2017	Staff reminded to document refused, dropped and disposed benzodiazepines in the book. **Closed from Accountable Officer's perspective** **CLOSED**
22/06/2017 **(Incident number** 129097) Whilst looking at history of medication given to patient, it was noted the recorded amounts exceeded the maximum dose when taking into account the recording of medication given by the district nurse.	2&3	23/06/2017	Awaiting further information.
08/06/2017 **(Incident number** 128707) Benzodiazepine stock check showed diazepam 1x5mg tablet short.	4	10/07/2017	• Continue daily benzodiazepine checks as per SOP **Closed from Accountable Officer's perspective** **CLOSED**
12/06/2017 **(Incident number** 128779) Service user called to request a repeat prescription of' what they had earlier in the week'. This was passed on to the consultant that the service user wanted a prescription of lorazepam. When the script was handed over to the service user they said that wanted zopiclone but decided to collect the lorazepam anyway. Prescription for zopiclone was requested for the following day.	4	04/07/2017	• Team pharmacist reviewed with the team and medic involved. Team members have been reminded to clarify medication needed before asking a medic to prescribe. Medic should check Insight notes to familiarise themselves with the client and the medication.
23/06/2017 **(Incident number** 129822) A T3 was issued for a client authorising an oral anxiolytic as regular treatment. However, the client was also prescribed prn anxiolytic. Client had received prn diazepam on	4	21/07/2017	• Senior pharmacists will continue to monitor any incidents involving T2/T3. **Closed from Accountable Officer's perspective** **CLOSED**

23rd, 27th & 28th June and 2nd July.			
24/06/2017 **(Incident number** 129139) Due to patient's presentation and refusal of any food, drink or medication, staff administered IM lorazepam.	4	03/07/2017	• Not a medication error.
27/06/2017 **(Incident number** 129212) Service user attended the clinic room for their morning medication of methylphenidate. This was administered, however, there wasn't another qualified staff member available to counter sign this.	2	27/06/2017	Management are aware that ward meetings will leave only one nurse to do a medication round Ward pharmacist has raised controlled drug incidents at ward governance.
29/06/2017 **(Incident number** 129265) Oxycodone is not highlighted as a cd on the JAC system, therefore does not ask for 2 qualified nurses to chart this.	2	17/07/2017	• Senior pharmacists and technicians made aware of need to ensure 2 witness signatures are prompted when adding controlled drugs to the JAC system. **Closed from Accountable Officer's perspective** **CLOSED**
29/06/2017 **(Incident number** 129301) Medication delivery received from Pharmacy. Delivery driver informed ward staff there were top-up files. This was not the case and was controlled medication, therefore this was not stored correctly.	3	30/06/2017	• Incident discussed with ward manager and nurses to ensure they are aware of signing procedures for controlled drugs. **Closed from Accountable Officer's perspective** **CLOSED**
01/07/2017 **(Incident number** 129341) Discrepancy of 5mg diazepam	4	03/07/2017	Continue monitoring benzodiazepine discrepancy, nurse reminder to be sent if there are increasing incidents. **Closed from Accountable Officer's perspective** **CLOSED**
02/07/2017 **(Incident number** 129353) Balance of 5mg midazolam ampoule incorrect. 19 in	3	06/07/2017	• Ongoing investivation

stock but records state 18.			
05/07/2017 **(Incident number** 127422) Whilst completing cd stock check, discovered a discrepancy of 6x 20mg oxycodone.	2	05/07/2017	• Nurses to continue checking CD cupboard carefully if discrepancy found. **Closed from Accountable Officer's perspective** **CLOSED**
05/07/2017 **(Incident number** 129426) When preparing a patients diazepam it was discovered that the previous evenings dose wasn't recorded in the drug book.	4	05/07/2017	• Staffing issues to be escalated by management; nurses to continue benzodiazepine checks as per SOPs. • Incidents to be discussed and reviewed in ward governance.
07/07/2017 **(Incident number** 129504) Whilst patient was being searched prior to seclusion, a white tablet fell from their person. When checking through the items removed from the patient, a strip of zopiclone were found amongst them.	4	12/07/2017	• Ward pharmacist discussed with ward manager post incident. • Confirmed SHSC personal search policy followed.
07/07/2017 **(Incident number** 125910) Whilst administering lorazepam, staff member noticed the number left in the controlled drug book was 85 when there should have been 84.	4	10/07/2017	• Deputy ward manager discussed issue in business meeting, reminders were given to staff to continue benzodiazepine checks and prompt CD recording after charting and recording wastage. **Closed from Accountable Officer's perspective** **CLOSED**
07/07/2017 **(Incident number** 130352) Service informed about an incident at a pharmacy on 07/07/2017. Service had issued 4 weeks and 1 day script. It appears that the patient took just the first 2 weeks prescriptions into the pharmacy initially. Patient then contacted the service requesting a restart as they had not had methadone since 02/07/2017. After this the patient took the second 2 week script into the	2	09/08/2017	• Staff / pharmacists vigilance prevented restarting after a treatment break. **Closed from Accountable Officer's perspective** **CLOSED**

pharmacy. Staff were aware and did not dispense.			
12/07/2017 **(Incident number** 129780) Following a full stock audit of medication across all areas of the unit, there were found to be anomalies of benzodiazepines as well as all other prescribed medication.		28/07/2017	• Switched to nightly audits • Ward liaised with Pharmacy for and further actions
17/07/2017 **(Incident number** 129719) Lorazepam tablet was not accounted for during benzodiazepine check.	4	17/07/2017	• Management have sent reminders to record any dropped, refused or disposed of medications. **Closed from Accountable Officer's perspective** **CLOSED**
18/07/2017 **(Incident number** 129750) During SOP medication checks it was observed that lorazepam 1mg tablets did not tally. One tablet could not be accounted for.	4	31/07/2017	• Nurse management has spoken to the nurses that missed recording in the benzodiazepine book. Guidance from Pharmacy given on retrospective entries in the book. **Closed from Accountable Officer's perspective** **CLOSED**
18/07/2017 **(Incident number** 129797) Whilst completing controlled drug check there was one lorazepam tablet missing.	4	20/07/2017	• For discussion at business meeting. Ward pharmacist aware of small discrepancies and will discuss at ward governance. **Closed from Accountable Officer's perspective** • **CLOSED**
19/07/2017 **(Incident number** 129784) The JAC system showed hat a client had exceeded their maximum dose of clonazepam. Prescribed max 6mg in 24hrs but 7mg had been administered. Patient causing disruption to the ward and was deemed high risk and was prescribed clonazepam as a form of managing agitation and aggression.	4	03/08/2017	• Nurses must check JAC and the prescription prior to administration.
19/07/2017 **(Incident number**	4	20/07/2017	• Low nurse staffing levels may be linked to missed recording of doses.

129793) When completing benzodiazepine check there was one lorazepam missing.			**Closed from Accountable Officer's perspective** **CLOSED**
20/07/2017 **(Incident number** 129800) During benzodiazepine, discovered diazepam 2mg was one tablet short.	4	20/07/2017	• Nurses reminded to be vigilant in documenting administrations and refused medication.
20/07/2017 **(Incident number** 129823) 1x5mg diazepam missing whilst carrying out daily check of benzodiazepines.	4	20/07/2017	• No trends of benzodiazepine discrepancies identified with the ward. **Closed from Accountable Officer's perspective** **CLOSED**
21/07/2017 **(Incident number** 129830) Clonazepam tablet missing during stock check.	4	21/07/2017	• Staff reminder to be sent by management (2 discrepancy incidents in last week). **Closed from Accountable Officer's perspective** **CLOSED**
21/07/2017 **(Incident number** 129834) While supervising service user take their medication, they picked up oxycodone 20mg and mistakenly took 6 tablets instead of the prescribed 3.	2	21/07/2017	• Team had restricted client's access to oxycodone and continue to review client regularly. **Closed from Accountable Officer's perspective** **CLOSED**
22/07/2017 **(Incident number** 129863) Patient was administered clonazepam at 22:00hrs. When recording this, staff nurse realised that the patient had received their 18:00hrs dose 2 hours late.	4	23/07/2017	Late doses should be discussed in nursing handover. • SOP states clinical appropriateness should be checked before administration – this includes but does not specify when last dose was given. **Closed from Accountable Officer's perspective** **CLOSED**
24/07/2017 **(Incident number** 129899) Staff member administered 30mg regular dose of chlordiazepoxide then gave 20mg prn when patient asked for it. When double checked, realised that the patient had already had the	4	25/07/2017	• Ward pharmacist has discussed controlled drug incidents in ward governance. Management aware of issues and recognise low staffing is a risk. New ward manager has started on this ward since the incident. **Closed from Accountable Officer's perspective** **CLOSED**

maximum daily dose.			
25/07/2017 **(Incident number** 129903) – During the benzodiazepine check a zopiclone 7.5mg was missing	4	07/08/2017	• Management to encourage nursing staff to be vigilant in recording all benzodiazepines/hypnotics even when not administered to avoid discrepancies. **Closed from Accountable Officer's perspective** **CLOSED**
27/07/2017 **(Incident number** 129978) – When carrying out SOP check, 3.75mg zopiclone was missing.	4	07/08/2017	• Medic informed of possible confusion and prescription altered to make clearer. **Closed from Accountable Officer's perspective** **CLOSED**
01/08/2017 **(Incident number** 130094) Stock check for diazepam 10mg, book stipulates 93 but there was only 76 in stock.	4	01/08/2017	Nurses performing checks to double check quantities carefully. Another member of staff should be contacted to help check if discrepancies are found. **Closed from Accountable Officer's perspective** **CLOSED**
01/08/2017 **(Incident number** 130104) – It was noted that a client's pain patch had come loose. Noted to have redness where old patches have been, action taken to be reviewed by GP.	3	01/08/2017	• Staff to follow policy of daily checks and body mapping
01/08/2017 **(Incident number** 130119) During telephone call with client's husband, he informed staff that he believed the client had taken and overdose of several medication (zopiclone, citalipram, panadol & Nytol). Staff member telephoned for an ambulance.	4	02/08/2017	• Medication involved not dispensed by SHSC. Overdose appears to have been impulsive. • DRAM updated with overdose risk. Psychological therapy offered. **Closed from Accountable Officer's perspective** **CLOSED**
04/08/2017 **(Incident number** 130181) Liquid diazepam stock balance appeared to be incorrect. 560mls	4	04/08/2017	To continue to monitor for discrepancies this quarter. Syringe tops to be supplied to wards to prevent loss through transfer. Wards to continue monitoring benzodiazepine stock balances and report discrepancies

documented but visual check appeared to be closer to 540mls.			**Closed from Accountable Officer's perspective** **CLOSED**
05/08/2017 **(Incident number** 130208) During SOP check it was observed that the clonazepam liquid didn't tally. 365mls was recorded but there was only 340mls in the bottle.	4	07/08/2017	• To continue to monitor for discrepancies this quarter. Syringe tops to be supplied to wards to prevent loss through transfer. Wards to continue monitoring benzodiazepine stock balances and report discrepancies. **Closed from Accountable Officer's perspective** **CLOSED**
07/08/2017 **(Incident number** 130288) – Benzodiazepine check showed there was a shortfall of 1x2mg diazepam tablets.	4	08/08/2017	• Discussed in governance and staff reminded about documenting procedures. **Closed from Accountable Officer's perspective** **CLOSED**
10/08/2017 **(Incident number** 130396) When preparing supplements for patient, staff member found additional tablets hidden within the medication dispensing pots. Paracetamol, diazepam & unknown tablet.	4	11/08/2017	• Management to discuss with all staff and in governance. Nurses reminded about importance of observing clients whilst administering benzodiazepines. **Closed from Accountable Officer's perspective** **CLOSED**
12/08/2017 **(Incident number** 130428) – Resident's patch was found on the bedroom floor. Staff checked his back and the patch was missing.	3	14/08/2017	• Staff to follow policy of daily checks and body mapping
13/08/2017 **(Incident number** 130432) When checking clonazepam tablets the number in the box did not match with the record book. The book stated 71 when there 73 in the box. Upon checking, it was noticed that a client had brought in their own medication and had been administered from this supply during night medication round.	4	14/08/2017	Incident raised with ward management and nurse agency. Management to be vigilant when booking agency staff that are new to the Trust and proved further training and support if needed. Patient's own medication removed from cupboard to avoid future errors. **Closed from Accountable Officer's perspective** **CLOSED**

15/08/2017 **(Incident number** 130493) Phone call received from community pharmacist. Patient had taken 3 times the amount of their normal daily dose by mistake as it was put in one bottle rather than 3 separate bottles for 3 consecutive days dosed of medication. Daily dose 25mgs methadone mix.	2	15/08/2017	• Incident shared with Yorkshire & Humber CD accountable officer and the CCG CD accountable officer. **Closed from Accountable Officer's perspective** • **CLOSED**
16/08/2017 **(Incident number** 130514) Pharmacy technician reported that the amount of lorazepam 1mg tablets in the CD book said 34 but the actual amount in stock was 33.	4	16/08/2017	• Management to continue reminding staff to sign benzodiazepine book after administration. **Closed from Accountable Officer's perspective** **CLOSED**
16/08/2017 **(Incident number** 130583) Client notified the service that they had taken an overdose of medication. Staff called for an ambulance	4	20/08/2017	• Warning placed on insight. Community pharmacy contacted to prevent future early dispensing. **Closed from Accountable Officer's perspective** **CLOSED**
18/08/2017 **(Incident number** 130555) CD stock check noted that 1x500mcg clonazepam was unaccounted for.	4	18/08/2017	Ward to continue reviewing and monitoring discrepancies. Discrepancies to be resolved at time to prevent them from being carried forward. • Reallocation of staff to cover vacancies on ward. **Closed from Accountable Officer's perspective** **CLOSED**
18/08/2017 **(Incident number** 130574) Benzodiazepine check showed the stock balance for diazepam 10mg was incorrect, 1 tablet short.	4	21/08/2017	• Medication to be returned to pharmacy if no clients currently taking. **Closed from Accountable Officer's perspective** **CLOSED**
18/08/2017 **(Incident number** 130584) Upon checking, a service users pain patch was missing.	3	21/08/2017	• Patient known to remove patches – staff usually place where he cannot reach but agency nurse unaware. • Site of patch checked daily and recorded on body map.

20/08/2017 **(Incident number** 130609) Service users' pain patch was missing. Staff stated that they had found what they thought was a dirty plaster on the floor and had thrown it away.	3	21/08/2017	• Confirmed with staff that patch had been disposed of. • Staff to follow policy of daily checks and body mapping
20/08/2017 **(Incident number** 130623) Patient informally admitted to ward. Informed staff only taken 2md diazepam and was unaware should not consume medication on the ward other than what the nurses administer.	4	21/08/2017	• Team to be extra vigilant during admission process. All service users to be asked about medication when arriving on wards. Search of belongings upon arrival on wards. • Information shared with other inpatient wards and prohibited lists/posters displayed on wards. • Referring teams to make service users aware that all medication must be handed to nursing staff. **Closed from Accountable Officer's perspective** **CLOSED**
21/08/2017 **(Incident number** 130624) Diazepam 2mg stock incorrect. 10 recorded but actual balance was 9.	4	21/08/2017	• Continue monitoring discrepancies. **Closed from Accountable Officer's perspective** **CLOSED**
21/08/2017 **(Incident number** 130646) – Benzodiazepine check showed clonazepam 500mcg was missing 1 tablet.	4	22/08/2017	• Discussed in governance and with ward pharmacist. **Closed from Accountable Officer's perspective** **CLOSED**
23/08/2017 **(Incident number** 130700) Clonazepam liquid 0.5mg/5ml stock incorrect. Previously listed at 250mls but stock check was 210mls	4	23/08/2017	• Further monitoring in current quarter for discrepancies as linked to another incident 131190. Ward Pharmacist to discuss in governance. **Closed from Accountable Officer's perspective** **CLOSED**
23/08/2017 **(Incident number** 130713) – During a review, a service user reported and incident at the chemist where they attempted to give him medication for another client with the same initials. He was unable to remember the	3	05/09/2017	• Incident to be reviewed by CCG. No clarity issues identified with prescription **Closed from Accountable Officer's perspective** **CLOSED**

date.			
24/08/2017 **(Incident number** 130744) Client was administered 2mg diazepam instead of 3mg.	4	05/09/2017	• Monitored for other incidents linked to nurse involved – none found. **Closed from Accountable Officer's perspective** **CLOSED**
25/08/2017 **(Incident number** 130772) Client's box of pain patches were not delivered by the pharmacy which meant the client was without a replacement patch.	3	25/08/2017	• Home manager to discuss with community pharmacy
26/08/2017 **(Incident number** 130785) Nurse attended to renew syringe driver for client. Upon handing over 3 x vials it was discovered that one vial was smashed.	2	31/08/2017	• Home manager informed. • Trust Pharmacy contacted and vial and packaging sent to them for examination.
26/08/2017 **(Incident number** 130789) When checking client, staff discovered the pain patch was missing.	3	28/08/2017	• Staff to follow policy of daily checks and body mapping
26/08/2017 **(Incident number** 130790) Client was observed to have pain patch missing.		28/08/2017	• Staff to follow policy of daily checks and body mapping
28/08/2017 **(Incident number** 130820) Client was discharged from general hospital. SHSC staff visited the client at home and removed previously prescribed temazepam. Staff later reviewed the client's discharge summary and noted they had been prescribed several medication including lorazepam (regularly instead of prn) and temazepam.	4	28/08/2017	• Medication removed from patient's house and reviewed by medic.
31/08/2017 **(Incident number**		01/09/2017	• Staff to follow policy of daily checks and body mapping

130900) Client's pain patch was found on their bedroom floor.			
02/09/2017 **(Incident number** 130945) Stock balance of 500mcg clonazepam was out by x1 tablet.	4	04/09/2017	• Greater vigilance with administration and record keeping needed. Staff to continue daily benzodiazepine to monitor for trend. **Closed from Accountable Officer's perspective** **CLOSED**
04/09/2017 **(Incident number** 130999) Client's pain patch was missing when staff checked.		04/09/2017	• Staff to follow policy of daily checks and body mapping
04/09/2017 **(Incident number** 131005) On checking the CD book, there had been 13 instances in the last 2 days of clonazepam, diazepam or lorazepam tablets not being countersigned.	4	05/09/2017	• Management to try and ensure all agency staff attending ward are aware of responsibilities and local SOPs. Ward pharmacist to consider training session of support workers if they are routinely asked to countersign due to staffing. **Closed from Accountable Officer's perspective** **CLOSED**
07/09/2017 **(Incident number** 131116) Administration of zopiclone was not charted on JAC.	4	08/09/2017	• Nurse management review of incident with staff involved and learning points to be shared with ward. **Closed from Accountable Officer's perspective** **CLOSED**
09/09/2017 **(Incident number** 131154) While cleaning in nurse office, staff member found tablets at the back of the filing cabinet; 1x diazepam, 1/2x diazepam & 1/2x unknown.	4	13/09/2017	• New clinic room with more space to be used in the future. Management to discuss medicines management and recording dropped medication in next staff meeting. **Closed from Accountable Officer's perspective** **CLOSED**
09/09/2017 **(Incident number** 131163) Diazepam oral solution 2mg in 5mls didn't visually match with the record book. 88mls left in stock but looks like approx 45mls.	4	13/09/2017	• All qualified staff to be reminded to record all benzodiazepines which have been dispensed. Including medication which has been declined and then disposed of.

12/09/2017 **(Incident number** 131238) Client was given oral medication but spat this out. IM lorazepam given instead.	4	12/09/2017	• No medication error found. **Closed from Accountable Officer's perspective** **CLOSED**
14/09/2017 **(Incident number** 131289) Client was administered 1000mcg clonazepam when only prescribed 500mcg.	4	15/09/2017	• Nurse has undertaken reflective practice which has helped them to understand how this incident occurred, They are clear of the steps he need to make to ensure this does not reoccur. • Medicines with Respect assessment will be completed.
14/09/2017 **(Incident number** 131299) Advised by the pharmacists at the community pharmacy that a client had presented twice the previous day. The client was successful because the pharmacist that serviced him the first time was on lunch.	2	18/09/2017	• Incident forwarded to the regional CD accountable officer & CCG. **Closed from Accountable Officer's perspective** **CLOSED**
15/09/2017 **(Incident number** 131326) Client was administered clonazepam 1000mcg when only 500mcg was prescribed.	4	15/09/2017	• See incident 131289 • Nurse has undertaken reflective practice which has helped them to understand how this incident occurred, They are clear of the steps he need to make to ensure this does not reoccur. • Medicines with Respect assessment will be completed.
15/09/2017 **(Incident number** 131364) Lorazepam stock balance was 3 tablets less than documented in the stock book.	4	18/09/2017	• Discussed in ward governance. Reallocation of staff to cover vacancies.
16/09/2017 **(Incident number** 131367) 2x3.75mg zopiclone was noted to be missing.	4	18/09/2017	Continue monitoring discrepancies. **Closed from Accountable Officer's perspective** **CLOSED**
17/09/2017 **(Incident number** 131365) During nightly benzodiazepine check, the	4	18/09/2017	• Discussed in governance. Reallocation of staffing to cover vacancies. **Closed from Accountable Officer's perspective**

lorazepam stock balance was 2 tablets lower than documented.			**CLOSED**
18/09/2017 **(Incident number** 131392) When completing daily stock check it was noted that clonazepam was down by 1 tablet and chlordiazepoxide was down by 2 tablets.	4	18/09/2017	• No management review. Discuss in governance. Pharmacy to continue to monitor discrepancies. **Closed from Accountable Officer's perspective** **CLOSED**
18/09/2017 **(Incident number** 131423) Service informed of the death of a client. Cause of death confirmed at Acute drug (heroin, benzodiazepine, alcohol) toxicity.			• No actions identified **Closed from Accountable Officer's perspective** **CLOSED**
19/09/2017 **(Incident number** 131432) Whilst completing medication round, staff noted that the stock of diazepam was down by 2 tablets. When JAC was checked it became clear that 2 clients had been administered diazepam the previous night but this was not recorded in the stock book.	4	19/09/2017	• Nurse management to review incident in team and discuss underlying causes of missed recording. **Closed from Accountable Officer's perspective** **CLOSED**
20/09/2017 **(Incident number** 131463) 500mcg clonazepam was recorded as administered instead of the prescribed 250mcg.	4	20/09/2017	• Staffing issue was raised by management during review, use of agency nurses and the training required for administering and recording of administration were discussed. **Closed from Accountable Officer's perspective** **CLOSED**
20/09/2017 **(Incident number** 131464) Balance of clonazepam 500mcg was down by 2 tablets	4	20/09/2017	• Trust policy around agency staff has now altered so that they are checked and Trust now has some oversight.
21/09/2017 **(Incident number** 131487) Community pharmacy informed the service that	2	28/09/2017	• Incident forwarded to regional CD Accountable Officer and CCG. • **Closed from Accountable Officer's perspective**

they had given a client two doses of methadone (85ml). They will dispense one dose less next time the client attends.			**CLOSED**
23/09/2017 **(Incident number** 131539) Client was given 7.5mg zopiclone in error due to mis-identification.	4	25/09/2017	Planned supervision with nurse involved to focus on medicines safety. Nurse later linked to serious incident (132664) so unable to review with them. **Closed from Accountable Officer's perspective** **CLOSED**
27/09/2017 **(Incident number** 131634) Administration of lorazepam was not recorded on JAC.	4	29/09/2017	• Management discussed with staff in supervision and high clinical activity recognised as underlying cause. **Closed from Accountable Officer's perspective** **CLOSED**
27/09/2017 **(Incident number** 131633) Pharmacist dispensed 2 days methadone in error. Client usually prescribed 85mg daily but was given 170mg in total.	4	28/09/2017	• Community pharmacy to report incident to their authorities.
28/09/2017 **(Incident number** 131640) Client approached the service after a 2 year absence seeking support for methadone. They disclosed that another client had been diverting their prescribed medication for monetary gain over the past 18 months.	2	28/09/2017	• DRAMs updated. Discussed in MDT. **Closed from Accountable Officer's perspective** **CLOSED**
29/09/2017 **(Incident number** 131674) Staff member stated that they had been administering controlled drugs and got development workers to sign as witnesses. This included counting and recording medication as well as administering. Would also get them to sing without actually being present.		29/09/2017	• All staff reissued with CD protocol and read and sign document and practice required
30/09/2017 **(Incident number**	3	01/10/2017	• Staff to follow policy of daily checks and

131702) Client's pain patch was missing when staff checked. Room fully checked but unable to find it.			body mapping
14/02/2017 **(Incident number** 125964) Service informed of the death of a client. Cause of death included 'excess fentanyl in the presence of diazepam.	2&4	20/11/2017	N/A • Prescribing and monitoring under the care of the GP
15/09/2017 **(Incident number** 131292) Nightly stock check showed there was approx 205ml diazepam liquid but the balance should be 250ml.	4	03/10/2017	• DWM has spoken to staff about reconciling the difference when a new bottle is started to avoid further discrepancies. • Ward pharmacist to discuss wastage protocol for liquids with Maple team. • Bottle stoppers sent to ward as discussed.
22/09/2017 **(Incident number** 131530) Service informed that a client had taken an overdose of medication the previous evening.	4	10/10/2017	• Impulsive overdose. Safeguarding concerns raised by home treatment team to Children and Families services as client took overdose whilst children were asleep in the house. **Closed from Accountable Officer's perspective** **CLOSED**
25/09/2017 **(Incident number** 131554) 1x lorazepam tablet noted to be missing during nightly check.	4	10/10/2017	• DWM was unable to identify the signature of the staff recording the later administered dose. A list for more up to date signatures was provided to the ward. • Targeted supervision planned for nurse involved when signatures sheet is completed. **Closed from Accountable Officer's perspective** **CLOSED**
01/10/2017 **(Incident number** 131727) 226 clonazepam tablets recorded in the book but actual count showed there were 225 tablets.	4	02/10/2017	• Significant staffing issues raised by management. High clinical activity noted between August-October and use of agency nurses to cover vacancies.
02/10/2017 **(Incident number**	3	03/10/2017	• Procedure not followed. Further investigation needed.

131747) Client was observed to have his pain patch in his pocket.)			
03/10/2017 **(Incident number** 131757) Client reported misplacing 3x bottles of methadone (50mg daily, total 150mg).	2	03/10/2017	• Client remained on daily pick ups except weekend and will be reviewed by medic this week to discuss whether pick ups can be reduced. **Closed from Accountable Officer's perspective** **CLOSED**
03/10/2017 **(Incident number** 131783) Whilst checking controlled drugs book and counting clonazepam, found that 190 tablets were left rather than the stated 191.	4	04/10/2017	• Unknown small discrepancy. • Clinic room located in nurse office • Limited space to administer medication **Closed from Accountable Officer's perspective** **CLOSED**
03/10/2017 **(Incident number** 131791) 2x500mcg clonazepam not accounted for.	4	04/10/2017	• Unknown small discrepancy.
03/10/2017 **(Incident number** 131795) Service informed of the death of a client. Possible overdose of oramorph.	5	23/11/2017	• Overdose. All harmful/Opiate medications thought to have been removed from house. **Closed from Accountable Officer's perspective** **CLOSED**
03/10/2017 **(Incident number** 132287) Doctor was asked to prescribe prn lorazepam for a patient but omitted to check the T3 – lorazepam was not stated on the T3. This was pointed out by nursing staff	4	25/10/2017	• Prescriber self reflection. • Covered in Junior Doctor induction. • Identified as a risk if prescribing PRN meds. Doctor completed a S62 and requested SOAD.
04/10/2017 **(Incident number** 131792) Nightly check showed there were 2x500mcg clonazepam missing.	4	04/10/2017	• Unknown reason – no learning identified. • Continue with daily stock checks. **Closed from Accountable Officer's perspective** **CLOSED** •
06/10/2017 **(Incident number**	4	06/10/2017	• Administration documentation process not followed.

131849) 5mg diazepam were down by 2 tablets and lorazepam injection 4mg/1ml was 4 vials short.			• Technician was aware of the SOP for returning medication. Unknown why wasn't followed.
08/10/2017 **(Incident number** 131891) 1x10mg diazepam noted to be missing during stock count.	4	09/10/2017	• Tablet was loose in box. To discard loose tabs and document in register. **Closed from Accountable Officer's perspective** **CLOSED**
09/10/2017 **(Incident number** 131885) Only 180mls of diazepam 2mg/5ml in stock but the record book stated 242.5ml. Diazepam 5mg were down by 1 tablet.	4	09/10/2017	• New bottle tops sent to wards to reduce spillages and discrepancies on transfer. **Closed from Accountable Officer's perspective** **CLOSED**
09/10/2017 **(Incident number** 131907) Unable to find pain patch on client during the afternoon check.	3	11/10/2017	• Patch changed as per mar chart. Team to consider use of tape to hold patch in place.
12/10/2017 **(Incident number** 131988) Staff unable to find pain patch on client as per MAR chart.	3	12/10/2017	• Importance of following the SOP patch positioning.
13/10/2017 **(Incident number** 132001) Client was given 55ml methadone instead of 50ml by the pharmacist.	2	13/10/2017	• Service to remind clinicians to undertake and document urine screens on Insight. **Closed from Accountable Officer's perspective** **CLOSED**
13/10/2017 **(Incident number** 132014) When dispensing a patient's night time clonazepam, staff noticed that the prescription says 10000mcg tds but should say 1000mcg tds.	4	13/10/2017	• Patients prescription should have been transferred from one ward to another without re-prescribing. **Closed from Accountable Officer's perspective** **CLOSED** •
14/10/2017 **(Incident number** 132017) One tablet was noted as	4	16/10/2017	• Incident review not completed. • Continue with daily stock checks.

missing during cd stock check.			
14/10/2017 **(Incident number** 132029) Diazepam 5mg was down by 2 tablets.	4	16/10/2017	• Patient in Maple Seclusion but was in transfer to Endcliffe. not recorded in maple control drugs book, nor recorded in Endcliffe control drug book. (2 teams involved and responsibility for charting not done) **Closed from Accountable Officer's perspective** **CLOSED**
16/10/2017 **(Incident number** 132057) Pain patch missing on client when checked.	3	17/10/2017	• Patch checked shiftly by nurse in charge and documented on e-mar.
16/10/2017 **(Incident number** 132063 – Staff unable to find patient's leave medication of 2x1mg lorazepam)		17/10/2017	• Full benzodiazepine audit done on 03/11/17. Missing Lorazepam were later found on the ward and returned to pharmacy. **Closed from Accountable Officer's perspective** **CLOSED**
17/10/2017 **(Incident number** 132085) When counting clonazepam 500mcg tablets it was noted that 2 tablets were missing.	4	18/10/2017	• New clinic room with more space due to open in January 2018. **Closed from Accountable Officer's perspective** **CLOSED**
21/10/2017 **(Incident number** 132199) During CD check it was noted that 1x5mg diazepam tablet was missing	4	23/10/2017	• Discrepancy reconciled. Ward pharmacists informed of incident for further monitoring. **Closed from Accountable Officer's perspective** **CLOSED**
22/10/2017 **(Incident number** 132235) Resident's pain patch was found in their clothing. A new patch was applied.	3	23/10/2017	• No issue with positioning of patch. • Patch checked on each shift.
22/10/2017 **(Incident number** 132236) When checking CD's, staff found that a resident's	3	23/10/2017	• In August there was an incident logged and a submission for a defective diamorphine amp. In the latter case the manufacturers acknowledged that while not a common problem – this had happened previously.

midazolam ampoules were broken.			
28/10/2017 **(Incident number** 132355) Client contacted the service requesting further prescription for zopiclone 3.75mg. Noted from Insight that a prescription was provided on 23/10/2017. It was identified that this had been left in the letter box and not handed to the client directly. Pharmacist at the community chemist confirmed that they had a record of a script for zopiclone on 26th.	4	30/10/2017	• No actions logged to prevent incident. • Care planning / documentation of plan to post. Unknown if completed.
30/10/2017 **(Incident number** 132385) 40mls or morphine sulphate documented in the stock book but when checked, there was only 32.5mls in the bottle.	5	31/10/2017	• Small scale discrepancy. **Closed from Accountable Officer's perspective** **CLOSED**
31/10/2017 **(Incident number** 132391) Stock check showed diazepam liquid was down by 6ml. Possibly due to wastage. Diazepam 2mg tablets were down by 1.	4	09/11/2017	• Nurse management have sent email reminders regarding dispensing and recording controlled drugs. •
02/11/2017 **(Incident number** 132447) Nightly benzodiazepine stock check found lorazepam 1mg down by 1 tablet.	4	02/11/2017	Management to continue encouraging documentation of refused/wasted tablets **Closed from Accountable Officer's perspective** **CLOSED**
03/11/2017 **(Incident number** 132477) Staff doing stock check noted that it was document there was 4 lorazepam injections disposed of due to being out-of-date. Pharmacy stock check stated there were 8 lorazepam injections. No other lorazepam injections could be found.	4	03/11/2017	• Ongoing investigation

04/11/2017 **(Incident number** 132492) Only 4mls of morphine left in bottle when there should have been 5mls	5	06/11/2017	• Management review not yet completed- 1ml discrepancy likely to be loss through transfer rather than missed recording.
06/11/2017 **(Incident number** 132535) Stock balance of oxycodone was incorrect.	2	06/11/2017	• Nurses reminded that CD register tallies with order book and patient's own medications should be entered separately into register. **Closed from Accountable Officer's perspective** **CLOSED**
07/11/2017 **(Incident number** 132563) Balance of zopiclone 7.5mg tablets was out by -2 tablets.	4	07/11/2017	• Awaiting investigation
07/11/2017 **(Incident number** 132588) Stock count was inaccurate. 2x500mcg clonazepam tablets missing.	4	07/11/2017	• Nurse has emailed other nurses on Endcliffe to reconcile balance. Greater vigilance needed with recording administrations and refusals.
07/11/2017 **(Incident number** 132596) Pain patch found folded on the floor at the side of chair. Service user was checked and none in situ.	3	07/11/2017	• Patch checked each shift by nurse in charge and documented on e-mar • Patch now placed lower down in the centre of her back • (Date and position of previous patch administered). • Continue to monitor if removing patch and discuss with GP and pharmacy.
10/11/2017 **(Incident number** 132670) Patient had been prescribed 1000mg clonazepam liquid. Patient had not been administered this medication in the past 24hours since prescribed. Nursing staff noted the incorrect prescribing and notified the doctor.	4	10/11/2017	• Strength of solution altered on JAC system to reflect micrograms rather than mg
14/11/2017 **(Incident number** 132762)	4	14/11/2017	• Discussed in staff meeting. • We discussed the incident with substance misuse worker and if this

Whilst on detox, client had been taking chlordiazepoxide. Staff then discovered he had been consuming alcohol.			could have been prevented in anyway. • Made care co-ordinator aware. • Made partner aware to stay with patient for a few hours to ensure she is safe after taking the mixture of alcohol and detox medication.
18/11/2017 **(Incident number** 132859) Nightly medication check showed the balance of clonazepam were down by one tablet.	4	20/11/2017	Clearer handover between wards during patient transfer. **Closed from Accountable Officer's perspective** **CLOSED**
25/11/2017 **(Incident number** 133034) 2x lorazepam tablets missing during the stock balance check.	4	27/11/2017	• No cause found. No further discrepancies in week following. **Closed from Accountable Officer's perspective** **CLOSED**
26/11/2017 **(Incident number** 133059) 1 tablet missing from packet.	4	27/11/2017	Follow up by ward pharmacist in governance. Encourage nurses to document wasted tablets. **Closed from Accountable Officer's perspective** **CLOSED**
28/11/2017 **(Incident number** 133106) SOP check showed 1x1mg lorazepam and 1x500mcg clonazepam unaccounted for.	4	28/11/2017	• Pharmacy technicians to be alert for benzodiazepine discrepancies in record book when top ups are done. Technicians can speak to nurse in charge and clarify whether missing tablets were found or need incident reviews.
02/12/2017 **(Incident number** 133206) Controlled drugs count showed that Lorazepam 1mg were +1 tablet. On checking, staff member had mistakenly signed for lorazepam instead of clonazepam.	4	04/12/2014	• To ensure best practice of two nurses involved in administration and countersigning processes wherever possible. Management addressing staffing to make this possible. **Closed from Accountable Officer's perspective** **CLOSED**
03/12/2017 **(Incident number** 133241) On checking the drug	4	04/12/2017	Team Pharmacist to follow up to ensure clear documentation. **Closed from Accountable Officer's perspective**

cupboard, there was 1 less diazepam than recorded.			**CLOSED**
04/12/2017 **(Incident number** 133253) Benzodiazepine check showed that liquid diazepam was down by 22mls.	4	04/12/2017	Clarified with nursing staff regarding use of syringes and tops for bottles. Ward pharmacist to follow up with ward. **Closed from Accountable Officer's perspective** **CLOSED**
05/12/2017 **(Incident number** 133297) Service user had been administered 1mg clonazepam at tea-time but this was not charted. Dose then administered by another nurse.	4	06/12/2017	• Prompt charting after administration to be advised to nurses.
05/12/2017 **(Incident number** 133301) On checking recently delivered stage medication, there was 1xbottle with 1x5mg diazepam and 1xbottle with 2x2mg diazepam. Client is only prescribed 4mg diazepam at 22:00hrs.	4	06/12/2017	• Nurse administrating second occasion in a week that has not recorded in CD book. Management plan to be addressed on 12.1.18
8/1/2018 (Incident number 134140) Noted during CD check that Diazepam 5 mg was down by one tablet. Dose administration not recorded.	4		• Reflective summary to be forwarded by nurse administrating and will be further explored in supervision
11/01/2018 (Incident number 134198) Diazepam 5 mg was noted to be down by one tablet during CD count.	4		• Nurse administrating second occasion in a week that has not recorded in CD book. Management plan to be addressed on 12.1.18
16/01/2018 (Incident number 134338) 500 mcg Clonazepam noted to be down by 2 tablets during stock check.	4		• This was found that had been administered but not recorded in CD book. • Ward manager has spoken with nurse involved.
12/02/2018 (Incident number 135075) Whilst completing CD check, it was noted that Diazepam 5 mg was down	4		• Discrepancy accounted for

by 2 tablets. Discrepancy accounted for.			
22/02/2018 (Incident number 135370) Noted whilst completing CD count that Diazepam 5mg was down by one tablet.	4		• Qualified staff reminded that they should ensure that they count the medication correctly and that they get a counter signature preferably another qualified staff.
26/02/2018 (Incident number 135443) Noted whilst completing CD checks that Lorazepam 1mg was down by one tablet. Also noted that one vial of orazepam 4mg/1ml was broken.	4		• Supervision conducted with nurse involved, review of action plan discussed
08/03/2018 (Incident number 135703) Lorazepam 1mg was noted to be down by one tablet during the CD stock check.	4		• Qualified staff to be reminded that they must check CD medication with preferably another qualified or, if not, a support worker.
10/03/2018 (Incident number 135781) On dispensing the drug clonazepam 500mcg tablets (controlled drug) and checking stock balance prior to dispensing medications it was noted that the stock balance stated 65 tablets but only 63 tablets were present.	4		• Incorrect documentation • Nurse manager informed- to speak to the nurse involved.
26/01/2018 (Incident number 134677) The resident's pain patch was due to be given 26/1/18 but was missed & not administered.	3		• Human error – missed dose
24/01/2018 (Incident number 134631) **25mls of Methadone administered to patient rather than 25mls of Sugar free Methadone.**	2		• Discussed with Pharmacy • Ensure that the controlled drug policy is adhered to
30/03/2018 (Incident number 136324) **Dose of diazepam given to patient to patient but not recorded on JAC (was recorded in benzodiazepine book). Subsequent dose administered as patient still distressed taking**	4		• Awaiting review

patient over 24hr max dose.			
25/03/2018 (Incident number 136176) **Patient medication not signed out of medicines cupboard – included benzodiazepines.**	4		• Awaiting review
11/01/2018 (Incident number 134219) Possible incorrect quantity of medication dispensed.			• No medication taken – no harm caused. • Ongoing review
18/03/2018 (Incident number 135999) Medication incident relating to confusion regarding patient's reducing quetiapine. Not a controlled drug incident.	N/A		• Ongoing review
26/01/2018 (Incident number 134652) Found fridge temperature to above normal range- pharmacy was contacted and advised to condemn I.M lorazepam and not to use it	4		• Appropriate advice given by Pharmacy department. • Medication returned to Pharmacy for disposal
09/03/2018 (Incident number 135835) Was completing the daily benzodiazepine and controlled drug medication balance check and there was 1 lorazepam 1mg tablet missing.	4		• Awaiting review
24/03/2018 (Incident number 136148) On routine stock Bezodiazepine check, Diazepam 5mg tablet was found to be 2 tablets short of documented total.	4		• Discrepancy accounted for • Staff reminded to record doses as per SOP
19/01/2018 (Incident number 134445) When staff completed stock check of benzodiazepines is was noted two clonazepam tablets where not documented for	4		• Awaiting review

20/01/2018 (Incident number 134483) When completed benzodiazepine noted that stock balance was wrong. One lorazepam tablet not accounted for.	4		• Awaiting review
26/01/2018 (Incident number 134661) **1x 5mg Diazepam tablet found in patient's room.**	4		• Awaiting review
02/02/2018 (Incident number 134867) Benzo stock check - Diazepam 2mg/5mlapprox 25mls (5mg) below documented balance	4		• Awaiting review
26/02/2018 (Incident number 135445) Whilst undertaking benzodiazepine SOP nightly stock check. x1 10mg diazepam unaccounted for. Unable to locate by going through service users prescriptions who are prescribed this	4		• Senior staff to complete an audit trail with both drugs to ascertain who administered the drugs. • Discuss with staff involved. • Complete medicines with respect with individual involved. • Discuss in supervision.
02/03/2018 (Incident number 135583) 4mg IM lorazepam (undiluted) was given to RA in error. Correct prescribed dose was 2mg IM			• Duty of Candour investigation ongoing
04/03/2018 (Incident number 135609) When staff member was completing Benzodiazepine checks it was noted one diazepam 10mg was not accounted for and missing	4		• Discrepancy now accounted for
13/03/2018 (Incident number 136060) **Patient disclosed that she had been given subutex by another patient. They were not prescribed this.**	4		• Awaiting review
14/03/2018 (Incident	4		• Awaiting review

number 135930) Patient given two doses of clonazepam 1mg with a shorter interval between doses than specified on the JAC prescription.			
14/03/2018 (Incident number 135877) **Staff member went to complete benzodiazepine check regarding clonazepam. On stock check noted four tablets not accounted for.**	4		• Awaiting review
18/03/2018 (Incident number 135985) When staff completed medication check two clonazepam tablets were found in a pot in the drug cupboard. The two tablets where not documented in the benzodiazepine book but when accounted for made the stock balance correct.			• Awaiting review
22/01/2018 (Incident number 134551) Benzodiazepine stock discrepancy – 1x 500mcg clonazepam tablet too many and 1x 2mg clonazepam too few. Suggests patient may have received incorrect dose.	4		• Senior staff to complete an audit trail with both drugs to ascertain who administered the drugs. • Discuss with staff involved. • Complete medicines with respect with individual involved. • Discuss in supervision.
26/02/2018 (Incident number 135466) Benzodiazepine record book inaccurate, ward stock and named client stock combined and administered dose not recorded	4		• Staff to ensure all prescribed medication is recorded at the point of administration. • Staff to ensure that the stock balance is checked prior to administering.
10/03/2018 (Incident number 135787) Patient was administered Clonazepam 500mcg instead of prescribed dose of 2mg.	4		• Medicines with respect to be undertaken with staff nurse involved in the incident. • Staff to ensure all prescribed medication is checked on the JAC prior to dispensing and again before administration. • When administering Benzodiazepines two members of staff to check correct dosage prior to dispensing.

22/03/2018 (Incident number 136119) Upon entering the drugs cabinet to administer Lorazepam 1mg for a patient it was noted there were two boxes of Lorazepam 1mg, the benzodiazepine record book only showed 9 tablets in stock	4		• Staff to ensure that all Benzodiazepine medication is accurately recorded and signed by two individual's, one being a qualified nurse. • Ensure regular checks are maintained on stock balances every day as per protocol.
07/03/2018 (Incident number 135702) Fridge recording too high, reads 8.1 Fridge contains: Lorazepam ,Humulin, Glucagen Hypokit	4		• Advice sought from Pharmacy and estates. To continue to monitor fridge temperatures.
09/03/2018 (Incident number 135747) Staff Nurse attended ward to counter sign for controlled drugs (Morphine). During this process it was noticed that there had been an error documenting the amount of the drug incoming to the ward. 100mls was stated instead of 63ml incoming.	2		• Audit of the amount of Morphine was conducted and found to be correct amount in stock. This was documented in the Controlled Drugs book and rectified to show the correct balance
06/01/2018 (Incident number 134356) Upon administering lunchtime medication it was noted that patient had taken two doses of Diazepam PRN throughout the night -meaning he has gone above BNF limits, which is not covered on his T3.	4		• Awaiting further review
16/01/2018 (Incident number 134395) Patient given prescribed lunchtime dose of 1mg lorazepam at interval of less than two hours from morning dose.	4		• Requires further investigation
14/01/2018 (Incident number 134337) Missed entry of Zopiclone 7.5mg in book. This has now been checked and corrected. no medications	4		• Awaiting further review

were missing or unaccounted for.			
10/03/2018 (Incident number 135769) Clonazepam 500mcg tablets were recorded as being 129 in stock at 1900 on 9 3 18. After one more was used at 1430 on 10 3 18 only 127 were left.. One is missing.	4		• Awaiting further review
30/03/2018 (Incident number 136309) Whilst being observed taking stage medications patient took an extra 500mcg clonazepam. This was questioned by nurse but patient had swallowed extra tablet before they could be stopped.	4		• Patient will be required to always put his medication in a pot prior to taking his medication to prevent extra tablets been taken in error.
06/01/2018 (Incident number 134121) Incorrect prescribing of chlordiazepoxide regimen resulted in multiple doses being charted in the early hours. Extra doses not given but would have resulted in overdose had they been. Prescription corrected by doctor the next day.	4		• Prescribing of chlordiazepoxide covered in JAC training. • Awaiting further investigation
28/01/2018 (Incident number 134691) Patient was given PRN Lorazepam 1mg instead of 0.5mg	4		• Awaiting further investigation
13/02/2018 (Incident number 135105) During routine SOP check lorazepam 1mg tablet was found to be missing	4		• Awaiting further investigation
22/02/2018 (Incident number 135372) Zopiclone 7.5mg tablets appears to be one down in Benzodiazepines book on nightly stock check.	4		• Leave medication supplied from ward rather than waiting for Pharmacy delivery. Incorrect documentation. • Pharmacy to follow up and remind ward to follow SOPs.
13/03/2018 (Incident number 135852) During routine SOPs check it was noted the following	4		• Awaiting further investigation

were down by 1 tablet each:diazepam 2mg, diazepam 5mg, and lorazepam 1mg. We have trawled the medicine charts, but each tablet could not be accounted for.			
17/03/2018 (Incident number 135987) Patient threw their medication on the floor – 1x 500mcg clonazepam missing upon picking them up.	4		• Awaiting further investigation
19/03/2018 (Incident number 136014) During the evening controlled drug stock check, there were two discrepancies noted in the controlled drug book: - Lorazepam 1mg tablets: 1 less than recorded in controlled drug book. - Clonazepam 500mcg tablet: 2 less than recorded in controlled drug book. After checking calculations in controlled book and matching these against the recorded administrations on JAC we were unable to account for these discrepancies.	4		• Awaiting further investigation
20/03/2018 (Incident number 136042) SOP Check found Lorazepam 1mg tablets missing one tablet	4		• Awaiting further investigation
20/03/2018 (Incident number 136043) SOP Check found Clonazepam 500mcg tablets to be incorrect with one tablet missing	4		• Awaiting further investigation
21/03/2018 (Incident number 136069) SOP check of Diazepam 2mg in 5ml found to be incorrect.	4		• Awaiting further investigation
21/03/2018 (Incident number 136068) SOP check of Zolpidem 10mg tablets incorrect as	4		• Awaiting further investigation

delivery of pharmacy stock incorrectly recorded. 28 Zolpidem 5mg tablets recorded as 10mg tablets.			
08/01/2018 (Incident number 134158) Possible transcribing error on information provided by ward to patient regarding diazepam. Discrepancy between information supplied and medication. Medication supplied by Pharmacy was confirmed to be the correct dose.	4		• Awaiting further investigation
15/01/2018 (Incident number 134488) Service user contacted by phone to confirm time of today's contact. He was slurred in speech and disorientated. He was asked directly if he had overdosed. He identified that he had taken an overdose of both zopiclone and mirtazepine (amounts declared inconsistent but ranging between 18 – 20 of both). Emergency services contacted and ambulance requested. " FIC's staff members agreed to go over to patient's house. Patient was taken by ambulance to accident and emergency.	4		• Awaiting further investigation
08/01/2018 (Incident number 134237) Phone called received in pharmacy from Northlands HTT to state patient had been supplied with 14 lorazepam tablets by pharmacy to cover the TTO dated 8/1/18. Although the TTO requested 14 days of lorazepam, a hand written note by the Dr on the TTO stated their intention for him to only receive 7 days of lorazepam at a time (hence 2x [7x 1mg lorazepam tablets]).	4		• Dispensary noted to be extremely busy in response to short staffing (sickness) • Awaiting further investigation
09/01/2018 (Incident number 134189) A member of staff from Northlands rang to say we	4		• Medication was sent to the team stated on drug card – teams reminded to update cards following reconfiguration. Pharmacy staff to reinforce this message

had sent leave meds for this client to incorrect home treatment team			to teams.
29/01/2018 (Incident number 134978) Methylphenidate returned to pharmacy by technician without appropriate documentation i.e. not signed into the CD register for witnessed destruction. Medication appears to have been destroyed without documentation being completed.	2		• Correct procedures around CDs need reinforcing, (this is covered in medicines management sessions)
15/03/2018 (Incident number 136968) Methylphenidate tablets supplied to Becton without patient's details on label and thus did not comply with CD requirements for supply to outside of SHSC.	2		• All staff reminded to follow the SOP for supplying controlled drugs to outside SHSC.
05/02/2018 (Incident number 134900) Out of date lorazepam supplied by community pharmacy**.**	4		• DRR to check expiry dates on medication before we give medication to patients or care homes. • Community Pharmacy informed.
11/01/2018 (Incident number 134227) During benzodiazepine check it was noted that one ampoule of IM Lorazepam is missing. Cross referenced with JAC and could not find the missing dose	4		• Awaiting investigation
11/03/2018 (Incident number 135790) Benzodiazepine stock check not completed on nights on Thurs 8th March and Fri 9th March due to high clinical activity. I have not been able to complete the check until around 06:15hrs this morning, again due to high clinical activity. I found the following balance discrepancies: Diazepam 5mg - 4 down. Lorazepam 1mg - 1 down. Zopiclone 7.5mg - 1 down. Zopiclone 3.75mg – 1	4		• Awaiting investigation

down. I have not had time to search through JAC to try to ascertain reasons for these discrepancies.			
26/03/2018 (Incident number 136202) On doing benzo check lorazepam stock count was down 2. Searched for these and checked mathematics however discrepancy could not be accounted for.	4		• Awaiting investigation
03/02/2018 (Incident number 134905) Patient discharged from RHH 2/3/18, methadone script sent to community pharmacy. Patient did not attend pharmacy, attended RHH where they dispensed methadone despite there being a live community script. They do appear to have communicated this between themselves. I have highlighted this due to potential risk of double dosing methadone	2		• Non-SHSC incident
18/01/2018 (Incident number 134440) Client's community pharmacy reported that they had dispensed his usual dose today after he had failed to collect this dose for three consecutive days. This is in contravention of clinical protocols.	2		• Pharmacist advised to report incident via appropriate means • Service User to be seen for re- start
19/01/2018 (Incident number 134489) Advised via the Saturday on call mobile that Boots the Moor had probably given this client another patient's methadone to take home for the weekend yesterday. Client px 40mg methadone and probably given 45mg methadone to take home.	2		• Advised pharmacist to complete an incident form and also inform client as part of the duty of candour
02/02/2018 (Incident number 134852) Patient collected 3 days	2		• SHSC Business Manager, informed.

medication from her pharmacy. Mistakenly issued with 15 x 5mg Diazepam Tablets instead of 15 x 2mg Diazepam Tablets. Pharmacist realised shortly after patient left and contacted us asking for patient's telephone number.			
16/02/2018 (Incident number 135209) Patient given supervised dose of methadone in community pharmacy containing 10mls more than prescribed dosage. Mistake not noticed until patient had left the pharmacy.	2		• Ascertained that the pharmacy will follow their internal incident reporting procedure. • Discussed with Consultant in Substance use.
09/03/2018 (Incident number 135734) Patient attended community pharmacy having missed 3 collections of methadone in a row which meant his prescription should have been suspended pending a medical review. This was missed by the pharmacy who issued a supervised dose of 85ml methadone along with 2 x 85ml doses in take home bottles to the patient who then left the pharmacy. The pharmacist them noticed the mistake and informed us.	2		• Immediately discussed with Team leader. • Advised prescribing consultant for action • Care record entered • Chemist advised to complete incident form
21/01/2018 (Incident number 134495) Weekly medication audit undertaken. Stock balance of Lorazepam incorrect. Controlled book states 30 actual amount 20.	4		• Awaiting further investigation
22/01/2018 (Incident number 134645) Staff counted the content of the lorazepam in the view of staff and discovered there was seven tablets when the previous night when counted there had been twenty	4		• Awaiting further investication

25/03/2018 (Incident number 136185) On completing medication audit found that patient had taken four doses of Diazepam 2mg instead of three as indicated on the box / prescription. Staff are supervising medications.	4		• Poor documentation on medication recording system identified. • Discussed in staff meeting regarding lessons learned. • Discussed in managers monthly governance • Discussed in supervision with the specific staff members involved.
19/01/2018 (Incident number 134466) Butec patch was missing at time of check (13:00). Despite searching her thoroughly we were unable to find her patch. Patch replaced at time of reporting and stocked balanced on e-mar.	3		• Staff to follow policy of daily checks and body mapping • Ongoing review by Pharmacy and ward
19/01/2018 (Incident number 134465) Butec patch was missing at time of check (13:00). Despite taking patient to her bedroom and searching her thoroughly we were unable to find her patch. Patch replaced at time of reporting and stocked balanced on e-mar.	3		• Staff to follow policy of daily checks and body mapping • Ongoing review by Pharmacy and ward
28/01/2018 (Incident number 134621) Patch missing	3		• Staff to follow policy of daily checks and body mapping • Ongoing review by Pharmacy and ward
27/01/2018 (Incident number 134683) Female patient's patch was checked approximately 17:30 this evening during medication round. However, staff attending to her personal care at 19:00, noticed that the patch had been removed by the patient. When asked, she had no insight into what had happened to the patch.	3		• Staff to follow policy of daily checks and body mapping • Ongoing review by Pharmacy and ward
29/01/2018 (Incident number 134720) During routine patch checks, it was observed that patient's transdermal	3		• Staff to follow policy of daily checks and body mapping • Ongoing review by Pharmacy and ward

analgesic patch had come unattached, this was further checked by HCA who confirmed patch was missing. New patch applied and EMAR adjusted as was inventory, fresh patch was further supported in terms of adhesion by scanpor tape.			
25/02/2018 (Incident number 135448) At the lunchtime medication round, nurse was carrying out the daily check to establish whether the Butec (buprenorphine)patch was in place on resident, but was unable to see the patch. Agency nurse also looked for the patch but was unable to see it.	3		• Staff to follow policy of daily checks and body mapping • Ongoing review by Pharmacy and ward
28/03/2018 (Incident number 136663) Patch had been ordered on monthly prescription however not arrived, requested it be sent from Boots at 14.00 however at 17.30 they phoned to state they did not have a prescription for this as it was out of date. Advised that they had received monthly order and that this should be dated for March. On further discussion it was that boots had not collected the controlled drug prescription from the GP surgery.	3		• To discuss further with management • Discussed further with boots • Discussed with GP
AO- QY Concern raised regarding doctor in Clover group's prescribing			• shared with NHSE CDAO – • investigation found no outstanding concerns **Incident closed**
AO- DC Staff member found guilty of assault- medication used inappropriately during assault			• Investigation found that SHSC unlikely to have been source of medication used **Closed from Accountable Officer's perspective** **CLOSED**
AO- 132664			• Procedures related to storage and

Fraudulent prescribing by nurse in trust.			control of FP10 HP reviewed and updated • Procedures relating to management of returned medicnes reviewed and updated • CD Lin to continue to investigate this with AO to ascertain extent of medications prescribed.

Appendix III

CD incidents Data headings available for review/interrogation within the CDAO incident spreadsheet

Report No	Enables incident to be linked to risk /safeguarding database
Incident Type	Highlights serious/major concern
CD Schedule	Lists schedule 2,3,4,4anabolic 5,or unknown
Incident Date	Date incident occurred
Incident Location	Incident Location
Date Received in Risk	Date incident report received in the risk dept
Date Received in Pharmacy	Date incident report received in the in pharmacy department/CDAO aware.
Person Reporting Incident	Name of the person reporting the Incident
Principal Person Involved	Name of the person Involved in the incident
Others Directly Involved in Incident-1	Names of others involved in the incident
Others Directly Involved in Incident-2	Names of others involved in the incident
Witness-1	Names of people who may hold additional information
Witness-2	Names of people who may hold additional information
Cause Group	Free text cause – not limited to pre defined causes
Cause 1	Free text cause – not limited to pre defined causes
Cause 2	Free text cause – not limited to pre defined causes
Prescribing Doctor / Practitioner	Name of prescriber
Consultant / GP	Name of Consultant / GP
Description of Concern	Free text Description of Concern
Contributory Factors / Action Taken / Outcomes	Contributory Factors / Action Taken / Outcomes
Recommendations	Recommendations to prevent recurrence/further harm
Follow-Up / Comments	Additional information that may only come to light after implementing recommendations
Further Action / Comments from Pharmacy Dept	Pharmacy specific additional information that may only come to light after implementing recommendations
Status	Flagged when closed