**Table 1**. Types of medication administration errors that were detected during the baseline measurement observation of medication administration rounds.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Number of errors  (% of total errors) | % error occurrence per total opportunity for error | |
| Dose omission | 79 (57%) | 5.1 |
| Over-dose | 7 (5.1%) | 0.5 |
| Under-dose | 5 (3.6%) | 0.2 |
| Extra dose | 1 (0.7%) | 0.06 |
| Wrong strength/concentration | 2 (1.4%) | 0.1 |
| Wrong drug | 1 (0.7%) | 0.06 |
| Wrong form | 19 (14%) | 1.2 |
| Wrong technique | 5 (3.6%) | 0.3 |
| Wrong time | 18 (13%) | 1.2 |
| Wrong patient | 0 | 0 |
| Clinical monitoring failure | 1 (0.7%) | 0.06 |
| **TOTAL** | **138 (100%)** | **8.9%** |

**Table 2.** Examples of errors that were observed during baseline observation and how they were categorised according to clinical severity

|  |  |
| --- | --- |
| **Severity of observed error** | **Examples** |
| Negligible | * Patient prescribed levothyroxine liquid, nurse administered levothyroxine tablet. * Patient prescribed diazepam tablet, nurse administered diazepam liquid * Emollient cream that patient was prescribed to receive was unintentionally omitted |
| Minor | * Dose of sertraline that was due was unintentionally omitted * Patient prescribed 20mg fluoxetine, nurse administered 40mg by mistake * Chlordiazepoxide dose for alcohol withdrawal was prescribed for 9am, but was not actually administered until 11:30am |