Patients who experienced at least one error with potential to cause severe harm	Drug mean VAS score	Patient maximum mean VAS score
45 year old male admitted with headache and ataxia, left sided weakness and urinary incontinence, with poor vision. Diagnoses for this episode were neoplasm of uncertain behaviour of pituitary, steroid induced diabetes mellitus. Length of stay was 17 days. Background medical history of giant hyper-vascular pituitary adenoma.		8.3
Dexamethasone 2mg once daily was prescribed pre-admission, during admission and active on discharge. Discharge prescription error contained prednisolone 2mg once daily rather than dexamethasone 2mg once daily.	8.3	
41 year old female presented with abdominal pain and diarrhoea. Medical history included chronic pancreatitis secondary to alcohol, seizure disorder, asthma, recurrent electrolyte and metabolic disturbance. Diagnoses for this episode were alcohol induced pancreatitis, hypokalaemia, nausea and vomiting, urinary tract infection. Length of stay 18 days.		7.5
Sodium valproate controlled release 800mg twice daily was prescribed pre-admission. This was unintentionally changed to 600mg twice daily on admission, and this error continued through to the discharge prescription.	7.5	
Pain team consulted during admission and recommended addition of tramadol to analgesic regime. This was not prescribed during admission and not prescribed on the discharge prescription.	5	
Loperamide 2mg three times daily was prescribed pre-admission and during admission. It was recorded as "not administered" for 10 days before discharge because plain film x-ray of the abdomen identified slight faecal loading. Loperamide 10mg three times daily was prescribed on discharge.	4.3	
39 year old male presented for routine cardiovascular investigations during which an abnormal echocardiogram was noted and he was advised to attend the emergency department. He had a history of left arm numbness over the previous 8 weeks with intermittent chest pain and palpitations. Also had mild right leg swelling, and was treated for a suspected superficial clot with enoxaparin for one month pre-admission. Medical history included type 2 diabetes, obstructive sleep apnoea and anxiety. Hospital investigations identified that the chest pain was not cardiac related. Diagnosis for this episode was chest pain, unspecified.		8.2
Risperidone 2mg once daily was prescribed pre-admission and during admission. Risperidone 12mg once daily was prescribed in error on discharge.	8.2	
Aspirin 75mg once daily was prescribed pre-admission and intentionally stopped during hospital admission. This was prescribed in error on discharge.	3.5	

69 year old male presented with dizziness, headaches and nausea. His wife reported him having a number of falls within the previous year. Diagnosis during this episode of care was intracranial haemorrhage. Length of stay was 9 days. Medical history included hypertension, ischaemic heart disease, paroxysmal supraventricular tachycardia, stage III chronic kidney disease, cerebrovascular disease.		7.8
Aspirin 75mg once daily was prescribed pre-admission and withheld during admission. The discharge prescription did not communicate whether aspirin was to continue or to stop, or that it was withheld.	7.8	
Doxazosin controlled release was prescribed pre-admission and withheld during admission. The discharge prescription did not communicate whether doxazosin was to continue or to stop, or that it was withheld.	5	
62 year old female presented with left pleural chest pain. Medical history included hypertension, asthma/ chronic obstructive airways disease, cellulitis, previous left deep vein thrombosis 36 years earlier. Diagnosis for this episode of care was multiple pulmonary emboli. Length of stay was 6 days.		8.4
Warfarin lifelong was commenced in hospital. The discharge prescription did not list warfarin.	8.4	
Seretide® 250 Diskus inhaler (salmeterol/ formoterol) was prescribed pre-admission. This was unintentionally omitted during inpatient care and omitted on discharge.	4.6	
70 year old male presented with increasing confusion, headache, cough. Medical history included ischaemic heart disease (previous coronary artery bypass graft), type 2 diabetes, chronic anaemia, recurrent deep vein thrombosis, cerebrovascular accident, cognitive impairment, falls. Diagnosis for this episode of care was acute on chronic renal failure, lower respiratory tract infection. Length of stay was 5 days.		8.2
Insulin aspart was commenced during admission but omitted from the discharge list.	8.2	
Insulin detemir was prescribed pre-admission and during admission but omitted from the discharge list.	7.6	
Examples of patients who experienced at least one error with potential to cause moderate harm		
34 year old male presented having collapsed, experiencing chest pain and with a question of seizure activity. Medical history included type 1 diabetes (with neuropathy), asthma, previous intravenous drug misuse, methadone maintenance, heart murmur, hepatitis B and C positive. Diagnosis for this episode of care was hypoglycaemic episodes in type 1 diabetes. Length of stay 7 days.		6.8
Insulin aspart 10 units three times daily was prescribed pre-admission. This was changed to 10 units morning, 8 units lunch, 10 units evening because of hypoglycaemic episodes. Discharge prescription unintentionally stated 10 units three times daily.	6.8	

Beclomethasone inhaled 200 micrograms twice daily prescribed pre-admission and during admission. Seretide 250 Diskus (salmeterol/ formoterol) was erroneously recorded as a pre-admission medication and prescribed during admission and at discharge.	4.2	
Zopiclone 7.5 mg at night used long term preadmission and prescribed during admission. Unintentionally omitted on discharge.	3.8	
34 year old male admitted with shortness of breath and production of green sputum. Medical history included shrinking lung syndrome secondary to systemic lupus erythematosus (SLE), recurrent chest infections, steroid dependent asthma. Diagnosis for this episode of care was asthma, shrinking lung syndrome secondary to SLE. Length of stay was 4 days.		4.2
Calcium/ Vitamin D3 was prescribed long term pre-admission but unintentionally omitted during admission and on discharge.	4.2	
Co-codamol was prescribed long term pre-admission and stopped during admission. There was no communication on discharge that this drug was intentionally stopped.	3.4	
Examples of patients who experienced at least one error with potential to cause minor harm		
77 year old female was admitted for observation following a polypectomy. Medical history included ischaemic heart disease, type 2 diabetes with neuropathy, hypertension, heart failure. Diagnosis for this episode of care was iron deficiency anaemia. Length of stay was five days.		3.2
Pregabalin 75mg twice daily was prescribed pre-admission and during admission. Unintentionally changed to 75mg once daily on discharge.	3.2	
66 year old female presented with acute severe onset headache. Medical history included hiatus hernia, hypertension, high cholesterol, vertigo, tinnitus, migraine, asthma. Diagnosis for this episode of care was aneurysm from the anterior communicating artery in the brain. Length of stay was 19 days.		2.7
Betahistine 16mg three times daily was prescribed long term pre-admission and during admission. Prescribed in error as 5mg once daily on discharge.	2.7	
Prochlorperazine 5mg three times daily was prescribed long term pre-admission. It was prescribed on the "as required" section of the drug chart during admission and was unintentionally omitted on discharge.	2.7	