

## [“Care Homes’ use of medicines study: prevalence, causes and potential harm of medication errors in care homes for older people” October 2009](#)

The objective of the study was to determine the prevalence and potential harm of prescribing, monitoring, dispensing and administration errors in UK care homes, and to identify their causes. The results of the study have generated much interest as the authors

call for action from all concerned to address the need for improvement.

The results found that 69.5% of residents involved in the study had experienced one or more medication errors. Contributing factors to the findings included:

- Doctors who were not accessible did not know the residents and lacked information in homes when prescribing.
- Home staff’s high workload, lack of medicines training and drug round interruptions.
- Lack of team work among home, practice and pharmacy staff.
- Inefficient ordering systems
- Inaccurate medicines records and prevalence of verbal communication
- Difficult to fill medication administration systems

### **Action**

In it’s discussion section, the authors of [Care homes’ use of medicines study: prevalence, causes and potential harm of medication errors in care homes for older people](#) make several suggestions that could contribute to improved patient safety in Care Homes.

These include:

- Exploring the suggestion of a lead GP for each home; ensuring appropriate monitoring of patients on riskier medicines and that all patient’s medication is reviewed by a pharmacist
- Consideration of one person, perhaps a pharmacist, having overall responsibility for medicines use in one or more care homes.
- Constant review of the use and accuracy of medication administration records. (The authors noted that lack of protocols and adequate staff training is an issue)
- Prescribing medicines for different times to ease busy morning drug rounds which can often be interrupted.
- Monitoring of omitted doses and ordering systems , particularly of “as required” medicines, to reduce administration errors from omissions when a drug is not required.