Research shows medication errors common on admission to mental health units

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Medication errors are common on admission to mental health services – according to new research from the University of East Anglia, Aston University, and the South Essex Partnership University NHS Foundation Trust.

Research published today in the *International Journal of Clinical Pharmacy* shows that medication errors occurred in 212 of 377 of patients (56.2 per cent) admitted to the assessment ward, between March to June 2012.

The errors were corrected by a simple pharmacy-led intervention, undertaken by the Trust's own dedicated pharmacy service. But the

research team found that if these errors had not been corrected, more than three-quarters of patients would have been exposed to moderate harm.

Dr Chris Fox, one of the researchers and a senior clinical lecturer at UEA's Norwich Medical School said: "As a medic I am very concerned that these errors could have caused real harm and demonstrate the importance of a pro-active multi-disciplinary approach to medication management."

The errors involved various medicines, including anti-psychotics, heart medicines and medicines for diabetes, which are used to treat a range of diseases including Alzheimer's disease, schizophrenia and bipolar disorder (previously called manic depression).

Ian Maidment, senior lecturer in clinical pharmacy at Aston University, who supervised the research, said: "We found that medication errors may affect over half of patients admitted to NHS mental health services.

"These errors were corrected by a simple pharmacy-led intervention. SEPT have a 'gold standard' dedicated pharmacy service, which aims to review the medication for every admission, and stop errors from reaching the patient and causing harm. Worryingly, we don't know how widespread such services are and recent national reports have identified a lack of pharmacy services in mental health."

Hilary Scott chief pharmacist at SEPT said: "We introduced pharmacy-led medicines reconciliation when pharmacy services in Essex were brought in-house in April 2010. This forms an important aspect of our clinical pharmacy service with almost all admissions to the mental health assessment unit benefiting from the service. This means that there is a higher probability that the medicines prescribed on admission correspond with those that the patient was taking before admission,

minimizing the risks associated with medication errors which commonly occur when a patient transfers from one care setting to another."

Ian Maidment added: "It is important to keep taking your medication as usual, even if you are concerned that there may have been an error. If you have any concerns please talk to your doctor or pharmacist."

He also highlighted the need for more research: "This project only studied errors when people were admitted to secondary care mental health services and less is known about the risk of such errors when patients move from secondary care to primary care. We need much more research on the frequency, and ways to reduce, these types of errors."

More information: Anne Child, Amy Clarke, Chris Fox, Ian Maidment. "A pharmacy led program to review anti-psychotic prescribing for people with dementia." *BMC Psychiatry*, September 2012. DOI: 10.1186/1471-244X-12-155.

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