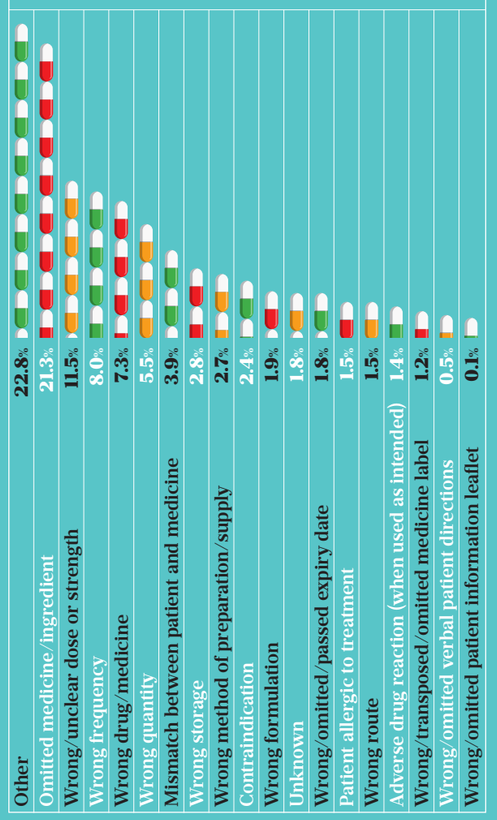
MEDICATION ERRORS: WHERE DO THEY HAPPEN?

Reducing medicines-related harm requires a clear understanding of where and when errors occur. This visual summary shows the latest estimates in England per year.

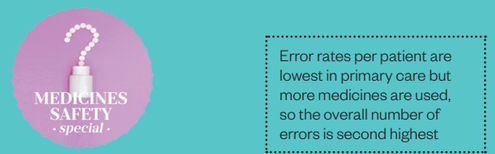
DAWN CONNELLY & MARTIN COTTERELL

TYPES OF ERROR

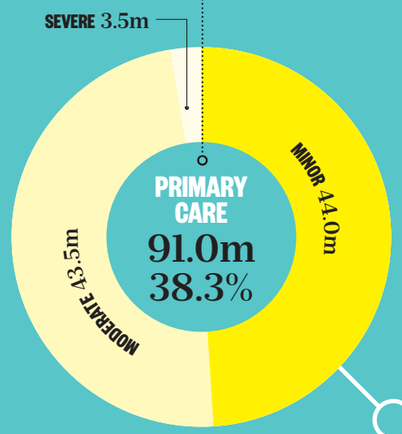
Around 204,000 medicines-related incidents were reported to England's National Reporting and Learning System during 2017–2018.

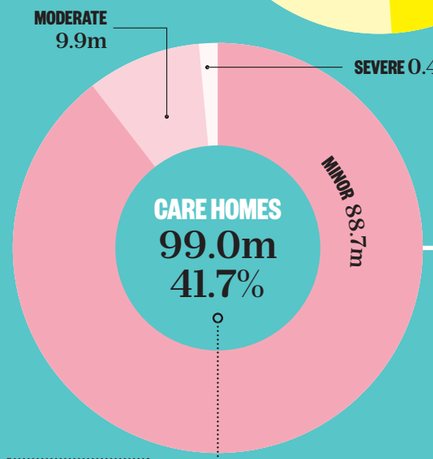


Source: Data obtained via a Freedom of Information request submitted by *The Pharmaceutical Journal* to NHS Improvement. Incidents reported to the NRLS as occurring between 1 April 2017 and 31 March 2018.

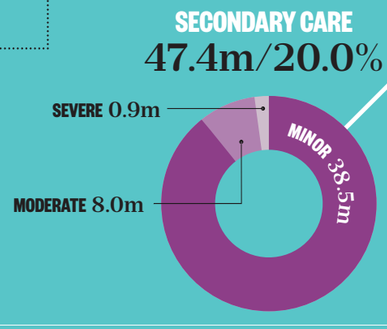


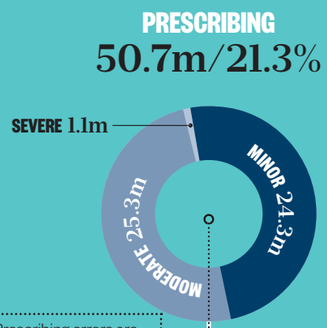
Error rates per patient are lowest in primary care but more medicines are used, so the overall number of errors is second highest



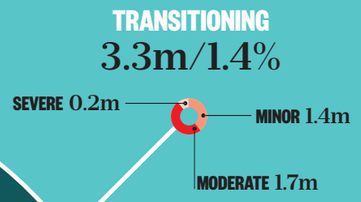


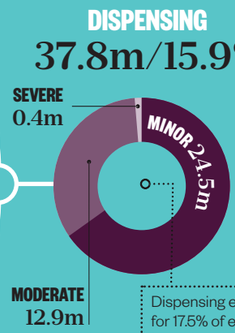
Care homes cover fewer patients than the other sectors, but have the highest error rates per patient, leading to a high overall number of errors



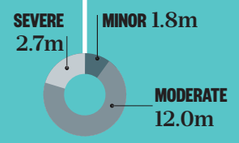


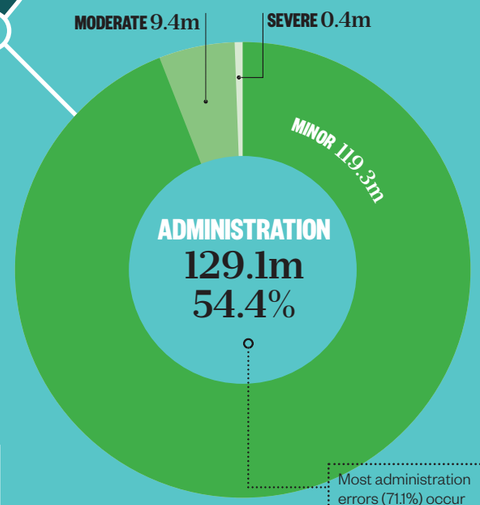
Prescribing errors are most likely to cause moderate harm (41.2% of moderate errors)





Dispensing errors account for 17.5% of errors that have the potential to cause moderate or severe harm in primary care





Most administration errors (71.1%) occur in care homes

MINOR: Error with little or no potential to cause harm
MODERATE: Error with potential to cause moderate harm
SEVERE: Error with potential to cause severe harm

MARTIN COTTERELL

Source: Policy Research Unit in Economic Evaluation of Health & Care Interventions. 'Prevalence and economic burden of medication errors in the NHS in England'. February 2018.

Deaths owing to definitely avoidable adverse drug reactions per year:

712

NHS costs of definitely avoidable adverse drug reactions per year:

POTENTIAL SOLUTIONS

Several strategies can be employed to reduce medicines-related harm.

- Roll out and optimise electronic prescribing and medicines administration systems
- Roll out proven interventions, such as PINCER, where pharmacists identify patients who are at risk from hazardous prescribing (*see page 95*)
- Improve the information available to patients to promote joint decision-making
- Use patient-friendly packaging and labelling
- Improve shared care across different settings
- Embed adequate training in safe and effective medicines use in undergraduate training and continuing professional development
- Encourage reporting of medication errors (*see page 120*)
- Reduce inappropriate polypharmacy

Source: Department of Health and Social Care. 'The report of the short life working group on reducing medication-related harm'. February 2018.

The World Health Organization wants to reduce severe avoidable medication-related harm globally by **50%** by **2022**