

Issue for consideration of Priorities Panel

For official use only:

Issue ID Number: ID 034

Date received by Operational Director
02/01/2010

Date to Priorities Panel
10/02/2010

Office use:

Name:
(JJ, RA, KT, All)

Date completed and initials:

Date of referral to LINK	12/01/2010
Date issue arose	07/01/2010
Title (Headline/short title of issue)	Medication Errors in Care Homes for Older People
Nature of interest/standing of person in relation to issue:	
Recipient of service	Family Friend Advocate/Campaigner
Other	✓
If other, please state what their standing is in relation to the issue:	
Interested party	
Is the person raising the issue a:	
LINK participant?	✓
Member of the public?	
Priorities Panel Member?	
Governor Group Member	
LINK Development Worker	
Part of an organisation	

<p>LINK Authorised Visitor</p> <p>LINK Authorised Representative</p> <p>KMN/Other</p>	
<p>If raising issue on behalf of an organisation, state name and brief details of what they do</p>	
<p>Summarise issue (no more than 100 words). If necessary, a more detailed account may be included below with additional pages attached if necessary</p>	<p>A recent research study examining medication, prescribing, dispensing, administration and monitoring practices across 55 care homes in West Yorkshire, Cambridgeshire and central London, strongly indicated there was considerable scope for improvement in how medicines are prescribed, dispensed, administered and monitored in residents and patients in residential care and nursing home settings in these areas. As a result, PCTs have been issued with guidance as to how they should address these findings in order to reduce the potential for errors to take place.</p>
<p>Please use this space to give a detailed account of the issue to be raised with the Priorities Panel. (N.B: Form will expand to accommodate additional text – other documentation can be appended, as necessary)</p> <p>The study aimed to determine the prevalence of all forms of medication errors in care homes, assess the potential of these errors for harm and establish the underlying causes.</p> <p>The main findings of the study were:</p> <ul style="list-style-type: none"> • residents (mean age 85 years) were taking an average of 8 medicines each • on any one day 7 out of 10 patients experienced at least one medication error • whilst the mean score for potential harm was relatively low, the results did indicate opportunity for more serious harm. <p>The results strongly indicate there is considerable scope for improvement in how medicines are prescribed, dispensed, administered and monitored in residents and patients in residential care and nursing home settings.</p> <p>Actions required by Primary Care Trusts are:</p> <ul style="list-style-type: none"> • To work with their primary medical care contractors, providers of 	

<p>information regarding incidents involving medication in care homes for older people from the PCT and Social Services</p> <ul style="list-style-type: none"> • Find out from PCTs how they plan to implement the recommendations which have been issued from the Department of Health in the wake of this study
<p>What would be a good outcome from the perspective of the person raising the issue?</p> <ul style="list-style-type: none"> • Clear local leadership and improved inter-professional communication between PCTs, medical contractors, providers of pharmaceutical services and social care to determine how medication errors in care homes can be reduced • For commissioners to implement the guidance from the White Paper and Royal Pharmaceutical Society of Great Britain and CQC standards when making relevant commissioning decisions, including considering how best to ensure adequate, sufficiently frequent and regular clinical review and monitoring of medication therapy, whether by GPs or pharmacists. • Fewer medication errors in care homes as a result of a more co-ordinated approach to medication administration and better staff training
<p>What evidence does the person raising the issue have to support the case they are putting for the LINK to take action? List or attach evidence and sources, if available.</p> <p>See research briefing attached</p>
<p>How widely does this issue affect other people?</p> <p>The homes investigated in the research were located in West Yorkshire, Cambridgeshire and central London; there several hundred care homes for older people in Kent and there is no evidence at present as to how widely such errors are taking place in the county.</p>
<p>In what ways are other people affected by this issue.</p> <p>The impact of poor medication administration on older people in care homes could be potentially very serious for those people in the homes concerned</p>
<p>Signed SS</p>
<p>Date 19/01/10</p>

**Recommendations proforma
ID 035**

No	Recommended action	Please tick	If additional information required, please specify	Additional comments, if any
1.	No further action			
2.	Watching brief			
3.	Letter to Trust/Social Care calling for comment before taking any further			
4.	Urgent action as issue concerns patient/client safety			
5.	Further information required, please specify			
6.	Consult/ survey participants to check level of interest/concern before proceeding to any other action			
7.	Start discussion on LINK web site/through LINK Bulletin			
8.	Question to Citizen Jury			
9.	Topic for local meeting			
10.	Urgent unscheduled visit –specify purpose of visit in comments column			
11	Refer to regulator, e.g. Care Quality Commission, Ofsted, Health and Safety Executive, Royal Colleges, etc –please specify			
12	Potential to develop as possible LINK project			
13	Any other recommended actions			