Publication: Prevalence, nature and predictors of prescribing errors in mental health hospitals: a prospective multicentre study

What did you do?

Pharmacists working in three NHS mental health hospitals were trained to identify and record any prescribing errors on newly written prescriptions for patients over 10 working days. Pharmacists were already used to finding these errors as it was part of their usual responsibilities. After the errors were identified, they were sent to a group of experts who looked at them to find out:

- that a prescribing error had actually happened
- what kind of prescribing error had occurred (e.g. was an important medication missed, or were two medications prescribed together that should not have been)
- how severe the harm may have been to the patient.

What are the most important findings/conclusions in this paper? Why are they important?

We found that errors made during prescribing affected more than 1 in 20 newly written prescriptions in the mental health hospitals we studied. Unlike earlier studies from general hospitals, we found that junior doctors working in the mental health hospitals we studied were less likely to make prescribing errors than their senior colleagues. The potentially harmful prescribing errors were found to be more common when the patient was admitted to or discharged from the hospital compared to during their hospital stay.

Our findings are important because other people can now use our results to think of new ideas to make the prescribing of medication safer.
Why did you conduct this research?

Errors when medicines are being prescribed are common in general hospitals, and may cause harm to patients. However, we know little about how common these errors are in mental health hospitals, what kinds of prescribing errors are likely to be seen, and what may increase the risk of an error occurring.

What was known before your paper was published?

Before this study was published, there had been some other studies which explored how common prescribing errors were in NHS mental health hospitals, and what kind of errors were seen. The number of errors was less than other studies had found in general hospitals. However, these earlier studies did not compare whether prescribing errors were more or less likely to be made by senior doctors compared to junior doctors, or whether errors were more or less likely to happen when someone was admitted or discharged from hospital compared with during their stay in the hospital. These comparisons had been made in studies exploring prescribing errors in general hospitals, where junior doctors were found to be more likely to make errors than senior doctors, but it was not known whether the same would be true in mental health hospitals.

What is next? What is the potential impact of the work in this paper? What will change as a result of this paper (or the study it describes)?

We hope that other researchers and healthcare workers use the results of our study to help them find new ways to make prescribing of medication to patients in mental health hospitals safer. By knowing what kinds of errors are seen, which types of medication are commonly involved, which groups of doctors may be more likely to make the errors and whether they are more common on admission/discharge from hospital or during their stay, we believe people will be able to find new ways of working to try and prevent errors in future.

Does this paper link in to a particular study / project? If so, please summarise the study and explain how this paper has improved understanding, or will move the study forward.

N/A