

# 2020

**Hertfordshire**  
**Safeguarding Adults Board**  
*Working together to prevent abuse*

## Medication Errors and Safeguarding Guidance for NHS Trust, Service Providers and Family Carers

## Appendix 5: Medication errors

### 1. Introduction

- 1.1 This guidance has been produced by the Hertfordshire Safeguarding Adults Board (HSAB). For those adults that need to take medication to maintain their health and wellbeing, it is *essential* to ensure that the adult has the right level of medication and has access to medication when necessary.
- 1.2 It is also important that medication is not given without consent. If the adult is unable to consent, then the evidence of this and a clear best interest decision must be in place. These must be reflected in the care plan and the care plan should be followed.
- 1.3 Hertfordshire County Council receives many thousands of notifications from providers concerning medication errors. This guidance has been produced to:
- Assist providers to determine the threshold for raising a safeguarding concern to the Council; and,
  - Align the threshold for raising a safeguarding concern with the threshold for statutory notifications set out by the Care Quality Commission (in respect of providers registered under the Health and Social Care Act 2008); and,
  - Align the threshold for raising a safeguarding concern with requirements set out in the terms and conditions of various legal contracts between providers and the Council; and,
  - Identify examples of the actions to be taken in respect of non-notifiable medication incidents, and how these actions will be assessed by the Council.

#### **NICE Guidance**

##### **Managing medicines in Care Homes**

<https://www.nice.org.uk/guidance/sc1>

##### **Managing medicines for adults receiving social care in the community**

<https://www.nice.org.uk/guidance/ng67>

### 2. Scope

#### 2.1 **NHS Trusts**

The Trusts already have their own policies in place and have provided an outline of their process. (see section 3).

#### 2.2 **Service Providers**

This guidance is relevant to accredited providers in respect of the following adult health and social care services:

- Residential Care Homes;
- Nursing Homes;
- Home Care (domiciliary care);
- Supported Living Schemes;
- Day Services;
- GPs;
- Pharmacists
- NHS Trusts
- Private Hospitals

(See Section 4)

#### 2.3 **Family Carers**

Where medications are administered by family carers mistakes can happen too. This guidance is to help those discovering such errors to determine if a safeguarding concern should be raised.

### 3. NHS Trusts

#### 3.1 **Medication errors in NHS Acute Hospital Trusts, HPFT, HCT, CLCH**

The NHS has a duty of candour and any patient who has been affected by a medication error will be informed of the incident.

Medication errors are reported through the NHS internal reporting system. These reports are reviewed by pharmacy or clinical unit and any incident which indicates a level of harm, neglect or abuse is escalated to the individual Trust's own safeguarding leads for scrutiny and decision around raising a concern.

The Trust will make a safeguarding referral to Adult Care Services (ACS) as per criteria in the Care Act 2014 (patient with care and support needs at risk of or experiencing abuse or neglect and not able to protect themselves) and co-operate with any resulting Section 42 investigation.

If there is significant harm to a patient or patients, an internal Serious Incident Investigation may also be triggered to establish the root cause of the error.

### 4. Service Providers

#### 4.1 **What is the threshold for raising a Safeguarding concern?**

4.1.1 A Safeguarding concern will ***always*** need to be raised where the medication error triggers a notification to CQC.

4.1.2 A CQC notification is required where the cause or effect of a medication error results in:

- Death
- Injury
- Abuse or an allegation of abuse
- An incident reported to or investigated by the police

4.1.3 **In addition**, HSAB expects a safeguarding concern to be raised where the person or persons in question came to moderate or potential harm as defined in the list below.

4.1.4 **If any of the following occur, a Safeguarding concern MUST also be raised:**

- Medication is given as a form of unlawful restraint (e.g. a non-prescribed sedative is administered, or a prescribed medicine is administered at a higher dose or more frequently than prescribed).
- A deliberate act to administer/neglect to administer medication contrary to the directions of the prescriber (e.g. deliberately increasing the dose of a medication or failing to administer it).
- A medication is administered covertly where no specific approved covert medication protocol is in place (e.g. administering a tablet in yoghurt where a client with or without capacity has refused).
- Consecutive/multiple medication incidents involving the same client (e.g. prescribed medication is not administered over more than one round because it has not been ordered or collected).
- Single medication incident involving multiple clients (e.g. a whole medication round missed or delayed).
- Multiple/repeat incidents within the same service, or by the same medication administrator (e.g. medication is administered incorrectly by a specific member of staff on more than one occasion).

4.2 **Examples of poor practice which do NOT trigger a safeguarding notification:**

- **A gap in recording** (eg a signature is missed on the MAR chart, but your investigation concludes that the medicine was correctly administered, no harm has

occurred, you have taken appropriate action with the member of staff concerned and recorded this).

- **Medication is not given on one occasion** (eg the adult does not receive prescribed medication (missed/wrong dose) on one occasion, a suitably qualified professional is consulted, and no harm occurs. You have taken appropriate action with the member of staff concerned and recorded this).
- **Medication is not given on more than one occasion and no harm occurs** (eg recurring missed medication or administration errors identified through observation or audit, a suitably qualified professional is consulted and no harm occurs. You take swift action once identify through training, supervision. You monitor the situation closely until poor practice has been corrected. You have recorded the incident and action taken/advice given).
- **Medication was given late** (eg an unforeseen event meant that some people received their medication later than scheduled, you have checked to ensure that no medication was time-sensitive and confirmed this with the GP who has advised that no harm has occurred, you have recorded the incident and action taken/advice given).
- **A member of staff has changed initials and the sample signature sheet reflects their previous name** (eg the member of staff signs the sample signature sheet again with their new initials and the date on which they started to sign MAR sheets with their new initials, the original entry remains on the sample signature sheet so that previous MAR entries can be traced to this person).

While the above examples do not trigger a safeguarding notification, they MUST trigger a management response through training, supervision or auditing. Remember to record what action/s you have taken.

#### **4.3 What action is required if a medication error does NOT trigger raising a Safeguarding concern?**

**4.3.1** Whether or not a medication error triggers raising a Safeguarding concern, **any identified poor practice in administration of medication requires a management response. A record of the incident should be made using a [Provider Form](#). A log of all errors should be kept. The [Provider Form](#) applies to HCC commissioned providers but can be accessed and used by others too.**

**4.3.2** This is because poor practice at any level which is not addressed can lead to medication errors which have a negative impact on clients. Taking action in response to all medication errors mitigates against the risk of reoccurrence and improves practice. Actions include:

**Audit – Conducting a robust, regular audit of medication systems will assist in ensuring that errors and trends are quickly identified.**

Look out especially for medications which sometimes have variable doses (e.g. Warfarin) those which are non-routine (e.g. antibiotics) and those stored other than in the medication cabinet (e.g. eyedrops and some topical creams) as errors often occur with these.

A good audit will check that stock is ordered in good time, that medication from the pharmacy is confirmed correct on receipt, that recording of administration, refusal and disposal is accurate, expiry dates are reviewed and that recording of administration is consistent with stock held. The frequency of audit should be increased where new staff are deployed to administer medication, and in response to errors identified.

**Investigate – It is important to investigate the cause of any medication error to determine whether written procedures need to be reviewed, individuals or teams of staff require additional training, or whether the risk of accidental error can be mitigated by implementing changes to practice.**

A thorough investigation report will include detail which might include statements of involved staff, anonymised copies of MAR sheets, care delivery records, communication with relevant parties (e.g. GP, Safeguarding, CQC), a written factual account of the investigation conducted, conclusion and action taken.

**Record – both as an audit tool and to evidence the action you've taken it is necessary to maintain a record of medication errors, their investigation and the action taken to address the incident.**

There is no requirement to establish a specific recording process if medication errors trigger an existing incident reporting procedure. Whichever recording procedure is adopted, it should be possible to periodically audit medication errors to determine error trends which in turn may identify a specific training need or the requirement for a Safeguarding notification. The Commissioning Team or Care Quality Commission may request information relating to medication errors to ensure that management processes are robust.

**Share learning – Even if the medication error is relatively minor in nature it is good practice to share learning.**

Effectively communicating learning from investigation of medication errors is critical to creating a culture where it is acknowledged that errors can and do happen. Learning shared in a manner which promotes improved practice rather than encourages staff to hide or disguise genuine errors for fear of punishment, is likely to result in more transparent disclosure of errors where they occur.

#### **4.4. Examples which MAY trigger raising a safeguarding concern and where advice should be sought first from senior manager or safeguarding lead within the service:**

- One off medication error for more than one person with no harm caused
- Previous concerns identified and corrective action is not maintained
- Insufficient prevention measures in place such as training, supervision and auditing.

Following the internal advice from safeguarding lead/manager, the concern should be escalated to ACS if necessary.

#### **Definitions of harm:**

**No harm:** Any medication incident that did not cause harm to the service user involved;

**Low harm:** Any medication incident that required a service user to have extra observation or monitoring, examples being an incident which required carers to contact NHS 111 or a G.P service for advice, an incident which required the service user to have an increase in the frequency of physiological observations;

**Moderate harm:** Any medication incident that resulted in a moderate increase in medical treatment delivered to a service user. Example's being incidents resulting in a service user attending an urgent care centre or emergency department for treatment or an incident which resulting in an increased hospital length of stay. Moderate harm incidents should not result in permanent harm;

**Severe harm:** Any medication incident that has resulted in or is likely to result in permanent harm to a service user;

**Death:** Any medication incident that contributes to a service user's cause of death.

#### **5. Family Carers**

For one off medication mistakes, resulting from the action or inaction of a family/informal carer that are of low harm or consequence, raising a safeguarding concern is not necessary. For example:

- missed medication or exceeding the prescribed dose
- if there is no thought that this was an act intended to cause harm

It should be considered whether the family member sought help or remedy (e.g. called 111, GP or another medical professional, requested a dosette box or a reminder process). Consideration of further support may be needed to prevent recurrence or signposting to relevant organisations for help.

If the carer is unwilling to accept help or support offered, this may indicate that this was not accidental, or if the error reoccurs then this would trigger the need to consider raising a safeguarding concern.

# Safeguarding Concern Chart

