North Somerset Safeguarding Adult Board

Medication Error Protocol

This is an approved North Somerset Safeguarding Adult Board document and should not be edited in any way

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1. Background and Purpose

North Somerset Safeguarding Adults Board recognises maintaining high quality services, including those provided by internally and externally commissioned providers, is essential to identify, respond to and minimise harm to individuals from medication errors.

It is recognised that for safeguarding to be relevant and effective it needs to be proportionate and have the capacity to respond to the more serious incidents where significant harm has occurred, or is likely to occur. Missed medication and medication errors, including error involving Controlled Drugs, are not necessarily a safeguarding issue. One off incidents of missed medication or other medication errors that cause no harm to the adult are not safeguarding issues.

This protocol provides guidance for staff in all sectors who are concerned that a medication incident (or drug errors) may have arisen as a result of poor practice, neglect or intention to cause harm. This guidance helps inform the decision whether to make a referral to the North Somerset Safeguarding Adults interagency procedures.

This guidance should be read in conjunction with the North Somerset Multi-Agency Adult Safeguarding Procedures.

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2. Introduction

Neglect is the deliberate withholding OR unintentional failure to provide appropriate and adequate care and support, where this has resulted in, or is highly likely to result in the person experiencing severe ill health or adverse effects.

All cases of actual or suspected neglect should be referred through the safeguarding procedures. Although not all poor practice is neglect, some may be. Poor practice may escalate in some circumstances for example, repeated minor errors. In such cases safeguarding adults concerns must be raised.

Medication incidents have a number of causes, including lack of knowledge, failure to adhere to system and protocols, interruptions, staff competency, poor handwriting and instruction, and poor communication (see definition of medication errors).

If indicated a safeguarding adults concern must be raised through the North Somerset Adult Safeguarding Multi-Agency procedures. The decision whether there is a duty to enquire is made by North Somerset Council Team.

3. Medication errors

Definition

"A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer."[2]

The following list gives examples of scenarios where medication errors can occur. Near misses in any of the sections below should also be considered. This is not a definitive or exhaustive list and as such clinicians, managers and clinical governance managers must exercise professional judgment prior to progressing the issue.

- Prescribing Errors
    - Patient prescribed the wrong medication/dose/route/rate.
    - Incomplete information e.g. no strength or route specified.
    - Medication omitted from prescription.
    - Medication prescribed to the wrong patient.
    - Transcription errors.
    - Prescribing without taking into account the patient's clinical condition.
    - Prescribing without taking into account patient's clinical parameters e.g. weight.
    - Prescription not signed
- Dispensing Errors
    - Patient dispensed the wrong medication/dose/route.
    - Medication dispensed to the wrong patient.
    - Patient dispensed an out of date medicine.
    - Medication is labelled incorrectly.
- Preparation and Administration Errors
    - Patient administered the wrong medication/dose/route.
    - Patient administered an out of date medicine.
    - Medication administered to the wrong patient.
    - Medication omitted without a clinical rationale.
    - Medication incorrectly prepared.

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[2] National Coordinating Council for Medication Error Reporting and Prevention (www.nccmerp.org).

- Unauthorised use of covert medication.
- Incorrect infusion rate.
- Medication administered late/early.[3]
- Medication deliberately not administered without good reason.
- Administration of medication recorded incorrectly or not recorded.

- Monitoring Errors
  - Patient known to be allergic to medication but the medication was prescribed and/or dispensed and/or administered.
  - Failure to provide the patient with correct information regarding their medication
  - E.g. when to take, what it is for, side effects.
  - Failure to monitor therapeutic levels.
  - Failure to monitor patient/carer who is undertaking self-medication.
  - Failure to react appropriately to signs of ill health, pain or requests for help due to being unwell – associated with medication administration.

- Other errors may include:
  - Poor or inadequate communication.
  - Poor, inadequate or incorrect recording/documentation.
  - Inappropriate or inadequate disposal of medicines.
  - Inappropriate administration of medication to chemically manage a patient's behaviour that has not been prescribed or giving additional doses to sedate patient.
  - Deviation from local policy and guidelines relating to Medicines Management
  - Errors may include Controlled Drugs. By themselves errors involving Controlled Drugs do not necessitate raising a safeguarding concern but may indicate a need for raising concern at an earlier stage.

[3] It is recognised that this is a complex issue and the full context of late/early administration should be taken into account. Where late / early medication administration would have a significantly detrimental effect on patient care, this constitutes an error.

4. Safeguarding Adults Decision-Making Process

When a medication incident or potential incident occurs, primary focus should remain on the adult's wellbeing. Staff should follow the agreed policy, procedure and reporting systems for their organisation, including reporting to CQC where relevant[4].

North Somerset Safeguarding Adults Board Threshold Support Tool should be used to support decision-making around whether or not to raise a safeguarding adults concern in connection with medication errors.

When completing the Threshold Support Tool consider:

1. Actual harm or risk of harm;
2. Previous medication or neglect incidents involving the adult at risk;
3. Previous medication or neglect incidents involving the specific staff member;
4. Previous medication or neglect incidents within the service.

Appendix 1 offers brief examples but is not a replacement for professional judgement.

[4] There is no requirement to notify CQC about medicines errors, but a notification would be required if the cause or effect of a medicine error met the criteria to notify one of the following: □□A death □□An injury □□Abuse, or an allegation of abuse □□An incident reported to or investigated by the police

Appendix 1: Case studies

Case study 1: Safeguarding concern not raised

- Care home manager discovers that on one occasion a person living in their service did not received their anti-depressant medication.
- The manager investigated and established that there have been no other concerns with the administering staff member's practice. A similar incident had occurred in the service nine months' ago.
- The GP was consulted who advised to continue as normal and that the risk of harm was minimal.
- The home manager found no link to the previous incident.
- The home manager put measures in place to assess the staff member's competency.
- The home manager recorded their decision-making process on the threshold support tool which concluded that a safeguarding adults concern did not need to be raised.
- The threshold support tool was stored as part of the patient's record.

Case study 2: Safeguarding concern raised using Threshold Support Tool

- Care home manager discovers that on one occasion a person living in their service did not receive their regular pain relief.
- The manager investigated and established that there have been no other concerns with the administering staff member's practice.
- The manager established that the person they support was observed to be acutely distressed on the day in question.
- The manager concluded that this change in presentation was an indication of acute pain. This was interpreted as the person they support having experienced harm.
- The GP was consulted who advised to continue as normal.
- The home manager recorded their decision-making process on the threshold support tool which concluded that a safeguarding adults concern needed to be raised on the grounds that harm had occurred.
- The threshold support tool was stored as part of the patient's record.

Case study 3: Safeguarding concern raised without using Threshold Support Tool

- A domiciliary care worker is found to have not prompted medication to 8 people on her morning round.
- The manager is aware that the care worker has previously been under investigation for a similar incident, with training and supervision given.
- The manager does not complete a threshold support tool in this case on the following grounds;
- It is clear that there is a concern around neglectful practice. Similar issues have previously been raised and the worker has had appropriate training and support. The manager therefore uses her judgement to decide to immediately raise a safeguarding adults concern.