North Somerset Multi-Agency Adult Safeguarding Procedures

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

Medication Error Protocol

Reference Number: M E D P O L 1
Author: Gavin Hutchison (Reviewer)
Document Owner: Business Manager - NSSAB
Approved by: NSSAB
Approval Date: 02/04/2025
Replaces: Medication Error Protocol (2019)
Equalities impact: n/a
Impact on carers: n/a
Date displayed on NSSB web site:
Date due to be reviewed by responsible person or body: 0 2 / 0 4 / 2 0 2 7
Reviewed by/changes made:

Contents

1. Background and Purpose 3
2. Medication errors 3
3. When to raise a safeguarding concern 5
4. Examples of poor practice that should NOT trigger a safeguarding notification 7
5. Safeguarding Adults Decision-Making Process 8
Appendix 1: Case studies 9
Case study 1: Safeguarding concern not raised 9
Case study 2: Safeguarding concern raised using Threshold Support Tool 9
Case study 3: Safeguarding concern raised without using Threshold Support Tool 10

1. Background and Purpose

North Somerset Safeguarding Adults Board recognises the importance of maintaining high quality care and support. This includes care and support provided by internally and externally commissioned providers. High quality care and support is essential to identifying, responding to, and minimising harm to people with care and support needs 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.

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

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

2. Medication errors

Medication errors have a number of causes, including lack of knowledge, failure to adhere to system and protocols, interruptions, staff competency, staffing levels/capacity, poor handwriting and instruction, and poor communication.

The National Coordinating Council for Medication Error Reporting and Prevention defines a medication error as

> "…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."

The following list gives examples of scenarios where medication errors/near misses can occur. This is not a definitive or exhaustive list and as such those supporting people with care and support needs must exercise proportionate 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.
    - Unauthorised use of covert medication.
    - Incorrect infusion rate.
    - Medication administered late/early.
    - 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.

Not all one-off medication errors will constitute a safeguarding concern. This will depend on the type of error, which medication was involved, and the impact this has on the person's health and well-being. When in doubt, log the concern with Care Connect.

3. When to raise a safeguarding concern

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.

It is important to note that not all poor practice is neglect. However, poor practice may escalate in some circumstances (i.e. repeated minor errors). In such cases safeguarding adults' concerns must be raised through the North Somerset Adult Safeguarding Multi-Agency procedures.

In addition to the above, 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 person with or without capacity has refused).
- Consecutive/multiple medication incidents involving the same person with care and support needs (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 people with care and support needs (e.g. a whole medication round missed or delayed).

The following examples MAY require a safeguarding concern to be raise:

- 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.

The decision whether there is a duty to enquire is made by North Somerset Councils Safeguarding Adults Team.

4. Examples of poor practice that should NOT trigger a safeguarding notification

- A gap in recording (e.g. 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 (e.g. the adult does not receive prescribed medication (missed/wrong dose) on one occasion and a relevant health care professional confirms no harm occurred. You have taken appropriate action with the member of staff concerned and recorded this).
- Medication is not given on more than one occasion and a relevant health care professional confirms no harm has occurred (e.g. recurring missed medication or administration errors identified through observation or audit. You take swift action once identified 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 (e.g. 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 relevant health care professional who has advised that no harm has occurred, you have recorded the incident and action taken/advice given).
- A member of staff signs the Medication Administration Record (MAR) chart in red ink (e.g. you have reminded the staff member of your policy and ensured a supply of black pens is available/removed the red pens).
- An error in recording/transcription during the booking in process that has not impacted on the administration of medication, however posed a risk of medication errors occurring as a result if not picked up (near miss) for example, a PRN medication has been recorded as regular dose due to transcription error or amount received / carried forward had not been recorded upon receipt.
    - PRN (Pro Re Nata) medicine should be administered ‘when required’, usually when the individual deems they are in need of it.

- A member of staff has changed initials and the sample signature sheet reflects their previous name (e.g. 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. Health providers will also complete incident reports that are examined internally. Remember to record what action/s you have taken.

5. 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.

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.

Appendix 1: Case studies

Case study 1: Safeguarding concern not raised

- Care home manager discovers that on one occasion a resident 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 resident 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 adult's 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.