‘

Adult Social Care

Medication errors guidance

Reshaping our practice

Name of document

|  |  |
| --- | --- |
| **Version number** | V5 Final |
| **Date** | 14/12/2021 |
| **Author(s)** | Jenab Yousuf |
| **Summary of change(s) and page number(s)** |  |

Contents

[Introduction 4](#_Toc93485557)

[What is a medication error? 4](#_Toc93485558)

[Responsibilities for regulated providers 5](#_Toc93485559)

[Best practice for the handling of medication errors 5](#_Toc93485560)

[Statutory requirements for reporting medication errors 5](#_Toc93485561)

[Raising a safeguarding concern following a medication error. 6](#_Toc93485562)

[When to raise a safeguarding following a medication error 6](#_Toc93485563)

[Systemic failings 7](#_Toc93485564)

[Covert medication 8](#_Toc93485565)

[Commissioning Responsibilities 8](#_Toc93485566)

# Introduction

This guidance has been produced to support health and social care providers in Buckinghamshire to understand when a medication errors is a Safeguarding concern.

The guidance is not intended to replace existing medication policies; however, it should be used as a reference document to ensure that existing policies are in line with best practice. Covert medication should not be given to adults who lack capacity without a decision being subject to a robust best interest decision in line with the Mental Capacity Act 2005. (see page 7)

## What is a medication error?

* The National Patient Safety Agency (NPSA) defines a medication error as *an error in the process of prescribing, dispensing, preparing, administering, monitoring or providing medicine advice, regardless of whether any harm occurred.*

For the purposes of making a decision about the need for a safeguarding concern then, if a medication error as defined above has occurred and in addition there is evidence of significant impact upon or significant harm to the individual subject of the error then a safeguarding concern should be raised. Otherwise, the error should be reported and recorded in accordance with your organisational policy and procedure for safeguarding/medication.

* Medication errors have a number of causes, such as lack of knowledge, failure to adhere to system and protocols, interruptions, staff competency, poor handwriting and instruction, poor communication, lack of training or basic human error.

|  |  |  |
| --- | --- | --- |
| **Medication Errors** | | |
| **Non-reportable** | **Requires Consultation** | **Reportable** |
| Incidents at this level do not require reporting as Safeguarding. However, agencies should keep a written internal record of what happened and what action was taken.  Actions/outcomes may include advice, information, risk management and staff training. | Incidents at this level should be discussed with the Buckinghamshire Council’s First Response Team. Call 0800 137 915 and speak to the team.  After the conversation you may be asked to formally report the concern. | Incidents at this level should be reported using the online form.  If there is any indication a criminal act has occurred, the Police **must** be consulted. |
| * Isolated incident where the person is accidentally given the wrong mediation, given too much or too little medication or given it at the wrong time but no harm occurs * Isolated incident causing no harm that is not reported by staff member * Isolated prescribing or dispensing error by GP, pharmacist or other medical professional resulting in no harm | * Recurring missed medication or errors that affect more than one adult and result in actual or potential harm to one or more adults * Recurring prescribing or dispensing errors by GP, pharmacist or other medical professional that affect more than one adult and/or result in harm to one or more adults * Covert administration without the person’s consent or having a best interest decision recorded in the care plan * Misuse of/over-reliance on sedatives to control challenging behaviour | * Deliberate maladministration of medications or failure to follow proper procedures e.g. controlled medication * Pattern of recurring errors or an incident of deliberate maladministration that results in ill-health or death * Deliberate falsification of records or coercive/intimidating behaviour to prevent reporting |

### 

### Responsibilities for regulated providers

* Regulated care providers/care settings who are commissioned to provide any medication administration service within a care plan are responsible for ensuring that people who require this service have their medicines administered at the times they need them and in a safe way.
* There must be a “Registered Person” who has responsibility to ensure safe practice when administering/dispensing medication.
* All staff administering/dispensing medication should have received appropriate training.
* In some service areas, individuals are encouraged to self-medicate as part of their care plan. Clear policies and procedures must be in place, and be followed, to support an individual safely and reduce the risk of harm arising from self-medication errors.
* Care providers must have clear procedures relating to arrangements for reporting any errors, adverse drug reactions, incidents and near misses relating to medicines.
* These arrangements should encourage local and where applicable, national reporting and learning and promote an honest, open and fair culture of safety.

### Best practice for the handling of medication errors

* Your organisation must have clear procedures for staff detailing how a medication error should be recorded, including specific processes for controlled drugs and reporting mechanisms to the Controlled drug accountable officer.
* All medication errors including near misses must be recorded. This record must detail the impact of the error, any immediate action taken and record the date, time and names of staff and individual/s involved.
* The error should be reviewed, and an action plan put in place to ensure lessons are learnt and shared with staff in order to reduce the risk of the error being repeated. It is also important to review the error in the context of previously recorded incident to identify themes and repetition of errors.
* Action should be taken to eliminate or minimise the effect of medication error on the service user(s) affected.
* There should be a regular schedule of investigating and reviewing medication errors via audit cycles. Learning and actions arising should be shared with relevant staff.

### Statutory requirements for reporting medication errors

* Your organisations “Registered Person” must protect individuals against the risks associated with the unsafe use and management of medicines, by means of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.
* There is no requirement to notify the Care Quality Commission regarding medicine errors unless the cause or effect of the error met the following criteria*:-*
  + A death
  + An injury
  + Abuse, or an allegation of abuse
  + An incident reported to or investigated by the police.
* Where relevant, you should make it clear that a medicine error was a known or possible cause or effect of these incidents or events being notified.
* These medication errors should be reported to CQC in line with the regulated care providers and management of incidents policy as soon as possible after the incident.

# Raising a safeguarding concern following a medication error.

Under the Care Act 2014, Organisations have a legal responsibility to raise safeguarding concerns where there is a suspicion that abuse of a vulnerable adult has occurred. This is supplementary to the requirements set out above around the management of medication errors.

*'Safeguarding means protecting an adult’s right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult’s wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action'.*

### When to raise a safeguarding following a medication error

Some examples of errors which **must** be considered for raising a safeguarding concern:

1. A medication error that leads to actual harm or death (*Some possible examples - not exhaustive)*

* People left without pain relief resulting in a prolonged period of pain
* Significant deterioration in physical or mental wellbeing due to missed medication
* Significant emotional distress
* Prolonging an illness due to medication not being given
* Causing harm or death due to wrong medication being administered.

1. Any medication error requiring medical intervention (*Some possible examples - not exhaustive)*

* Attendance at A&E
* The need for an urgent review by health professionals i.e. district nurse, ambulance service, GP or Tele-med consultation as a result of the error causing harm

1. The medication error was a deliberate act (*Some possible examples not exhaustive)*

* Malicious intent to cause harm
* Inappropriate use of PRN medication (also known as ‘as required’ medication)
* Use of medication to control behaviour or restrict an individual

1. The medication error is part of a pattern or culture. The pattern could be same drug, same carer or same vulnerable person. (*Some possible examples not exhaustive)*

* Same drug being omitted repeatedly
* Same carer repeatedly failing to administer medication appropriately
* Same individual being affected by the medication error regardless level of harm

Where any of the above four criteria for a safeguarding concern apply, services must also raise a safeguarding concern.

### 

### Systemic failings

Where there are systemic failings in a care providers medicine management process which leads to repeated medication errors, a safeguarding concern should be raised under organisational abuse.

Where an error is due to external factors or services e.g. pharmacy error, mismanagement by family, hospital discharge, GP prescribing etc. there is an obligation on all services to identify the failing and ensure the issue is addressed.

This can be done through contacting the appropriate services to support a resolution. This could include local medicine management team, GP’s, Social Workers or Care Co-ordinators, family members, or discussing with commissioners of local services.

# Covert medication

Covert administration is when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in a drink**.**

Clinicians and carers **should not** administer medicines to a person without their knowledge **if the person has mental capacity to make decisions** about their medical treatment . Covert administration can only be considered where the person has been deemed to lack capacity to consent to that specific treatment. It is not an all or nothing approach where a person is taking medication for more than one condition, their capacity to consent to treatment for each condition needs to be assessed separately. This may lead to some medications being administered in the usual manner with right to refuse noted and other medications being considered for covert administration.

A decision to administer medication covertly is very serious and should be made within the legal framework of the Mental Capacity Act/Deprivation of Liberty(DoLS) in addition to complying with ‘organisational and professional bodies’, guidance and policies. As part of the assessment process this should be clearly evidenced as a Best Interest Decision.

A decision to administer medication covertly should never be taken in isolation and must always include a Prescriber, a Pharmacy Adviser, the people administering the medication and other people interested in the person’s welfare (see Mental Capacity Act guidance on best interests and serious medical treatment).

# Commissioning Responsibilities

Medication Errors are reviewed as part of the contract monitoring process. Commissioners will seek assurance that: -

* the commissioned services have policy and processes in place on how to deal with medication errors in line with CQC and NICE guidance.
* all the staff within the commissioned service have had up to date training on medication management.

All Safeguarding referrals are recorded as Organisational Safeguarding concerns on BC’s client information recording system (LAS)which will support monitoring of themes and patterns for specific providers/settings.

This information could trigger an earlier or additional contract and monitoring review/visit.

As part of Quality monitoring this information is used to triangulate a joint response to identify and manage wider concerns.